Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 02/29/2012 1916 Oliver Bernard Johnson 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Montgamery Rockville 205 Dawson Avenue, #205B If Under 1 Year Social Security Number . Age (In yrs. last birthday If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) Days Hours 06/13/1923 1X M 2 88 216-16-0166 Usual Residence of Decedent 10b. County 10d. Inside City Limits 10c. City, Town or Location Rockville 1 X Yes 2 □ No Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 205 Dawson Avenue, 20850 #203B 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Force Black, White, etc. 1 Yes 2 No
If Yes, Give
Year or Dates. 1X Never Married 2 Married 1 ☐ Yes 2 XNo Specify. 3 Divorced Specify: Black 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 12th Heavy Machine Operator Construction 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) unk 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 414 College Park Way, Rockville, MD 20850 Jeffrey Bernard Palmer/son 20a, Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Cremation Svc 03/02/2012 Hanover, MD Ardent Signature of Funeral Service 22. Name and Address of Facility Snowden Funeral Home 246 N. Washington St, Rockville, MD 20850 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between

Enysician/ Medical Examiner

Physician/

Medical

10a. State

MD

Directo

Funeral

Completed by

Be

ပ

Examiner

Funeral

Director

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event, the Medical Examiner must be notified at once.

Baltimore, Maryland 21215-0036

physician and the burial-fram g

Re Completed by Dhysician/Medical Eyam signed by the a should page 2 Modical Cortificato: To within 24 hours after death

To the Funeral Director: /

To the Hospital or Attending Physician: The law requires that the death certificate be executed

Division of Vital Records, P.O. Box 68760

	Immediate Cause (Final disease or condition	AsHo			Onset and Death		
	resulting in death)	Due to (or as a consequence of):					
	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Unsease or impury	Due to (or as a consequence of):					
	that initiated events resulting in death) Last	Due to (or as a consequence of):					
y Signature	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown		ctopic pregnancy her (specify)		23d. Date of delivery Month Day Year		
60 00	Part II. Other significant conditions con-	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use 1 Yes 2					
				24a. Was an autopsy performed?			
,	25. Was case referred to medical		26. Place of Death (Check	only one)			
2	examiner? 1 2 Yes 2 No	ospital: 1	Other: 4 \(\sum \) Nursing Hor	ne 5 Residence	6 ☐ Other (Specify)		
	27. Manner of Death 1 Natural 5 Pending 2 Accident Investigation 3 Suicide 6 Could not be	28a. Date of injury (Month, Day, Year) 28b. Time of injury	28c. Injury at work? M 1 Yes 2 No	8d. Describe how inju	ury occurred		
-	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At home, farm, street, building, etc. (Specify)	factory, office 2	28f. Location (Street a City or Town, Stat	nd Number or Rural Route Number, ie)		
	(Check 2 Medical Examine	cian: To the best of my knowledge, death occu er: On the basis of examination and/or investigat Practioner: To the best of my knowledge, death	ion, in my opinion, death occurred at	the time, date and place	ce, and due to the cause(s) and manner stated.		
	20h Signature and title of certifier		29c License number	204 0	late signed (Month Day Year)		

21018

Georgia Ave-#104; Silver Spring,

3/1/12

MD 20902

Registrar DHMH 17 Rev 7/2009

State

DMO

Betsy Ballard,

(Month, Day, Year) MAR U 2 2012

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

10301

2. Registrar's Sign

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death February 26 2012 Physician/ 0726 Terry B. Johnson Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Anne Arundel Medical Center **Annapolis** Anne Arundel 9. Birthplace (State or Foreign Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth **Funeral** (Month, Day, Year, Hours Country) 220-58-1404 **Director** 1**X** M 2 □ F Aug 27 1953 58 Maryland Usual Residence of Decedent 28a-f show 10c. City, Town or Location 10d. Inside City Limits 10a, State ral", or items 23a or 28a-f sho Examiner must be notified at Director 1 Yes 2X No Maryland Anne Arundel Annapolis 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 812 B Newtown Dr. 21401 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No Black, White, etc. "natural", or ģ 1X Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2X No Specify: Black. 3 Widowed 4 Divorced Completed Year or Dates other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Page 1 and 2 should be filed within 72: nent of Health and Mental Hygiene. nt: If item 27 is marked other than "n ry or other traumatic (Specify only highest grade completed) Elementary/Second /Secondary (0-12) College (1-4 or 5+) Ò Self Employed Laborer Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame, Bernard Johnson Alverta Gross 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Pamela J. Hyman(Sister) 209 Ash Lane Annapolis, Md. 21409 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of metro Crematory or other place) 1 Burial 2 X Cremation 3 Removal from State permit. Page Department of Important: If any injury or 2-29-12 Baltimore, Md. 4 ☐ Donation 5 ☐ Other (Specify) Winname Remember & Scill Sons Mortuary, P.A. 21. Signature of Funeral Service Licenses 1922 Forest Dr. Annapolis, Md. 21401 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Cardionnyonathy Ph_sician/ disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate Examine Due to (or as a consequence of) Cause (Disease or injury attending physician and for use as the burial-tran that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be 24 hours after death.

Funeral Director: After this certificate has been signed by the attending physicial P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Year Pregnant at time of death 5 Other (specify) signed by the a Id be detached for 1 ☐ Yes 2 L 9 ☐ Unknown g [] Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records, been sig Completed Were autopsy findings available prior to completion of cause of 24a. Was an page 2 performed? 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director; After this certific completely filled in by the funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 \(\triangle \) Nursing Home \(5 \) Residence \(6 \) Other (Specify) 1 ☐ Yes 2 ♣ No ျှ 1 Npatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred M Natural 5 Pending iniury Accident Investigation 6 Could not be 3 Suicide
4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) Du6052 2/26/12 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Parkway, annapolis, Top

State Registrar 31. Date filed (Month

FEB 2 9 2012

DHMH 17 Rev 06-2011

32. Redistrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death +115 A Physician/ ohnson 12DY 491 tanc Medical ^{4a.} Facility Name (*if not institution, give street and number)*Assisted Living Well Compassionate
Care 4c. County of Death 4b. City, Town, or Location of Death Examiner Anne Arundel Millersville If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Birthplace (State or Foreign Country) Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Social Security Number **Funeral** Days 91 1 🗆 M 2 💢 F Director 039-05-1849 Jan. 22,1921 Rhode Island iral", or items 23a or 28a-f show Examiner must be notified at 10d. Inside City Limits 10b. Count 10c. City, Town or Location 10a. State 72 hours after death with the Maryland Director 1 🗌 Yes 2 🔀 No MD Anne Arundel Severna Park 10f. Zip Code 10g. Citizen of What Country? 10e Street and Number Funeral 21146 USA 502 White Oak Drive 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces?

1 Yes 2 XNo
If Yes, Give Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛣 No Specify: Specify: White "natural", Completed 3 ★ Widowed 4 □ Divorced Year or Dates. the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hyglene. Important: If item 27 is marked other than 'any injury or other traumatic event, the Me Elementary/Secondary (0-12) College (1-4 or 5+) Yarn Shop Owner Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Elizabeth Crapon Clarence L. Briggs 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 311 Spruce Avenue Edgewater, MD 21037 D. Randolph Johnson / Son 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date March 05, 2012 1 ☐ Burial 2X Cremation 3 ☐ Removal from State Baltimore, MD Metro Crematory, INC. 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
Barranco & Sons, P.A. Severna Park Funeral Home
495 Ritchie Hwy, Severna Park, MD 21146 21. Signature of Funeral Service Licensee 23a. Part . Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or bear failure. List only one cause un each line. Immediate Cause (Final Ph sician/ disease or condition resulting in death) Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury as a consequence of Exami for use as the burial-tran that initiated events Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical the Hospital or Attending Physician: The law requires that the death certificate be P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy

Live Birth 2 Fetal death

Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 5 Other (specify) in the past 12 months? Month Day 2 No signed by the a 1 ☐ Yes 2 ☐ Unknown g 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by POTHYROID, ANEMIA, cate has been signe, page 2 should be 2 No 3 Probably 4 Unknown Division of Vital Records, ISEASE, MACHLAR 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? perform within 24 hours after death.

To the Funeral Director: After this certificate 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? filled in by the funeral director, 26. Place of Death (Check only one) Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) ၉ 1 Yes 2 140 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certificate: 28c. Injury at 1 Natural injury work? 1 ☐ Yes 2 ☐ No 5 Pending Accident Investigation 6 Could not be Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical Ecrtifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated completely Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29d. Date signed (Month, Day, Year) 29b. Signatu and title of and address of person who completed cause of death (Item 23a) (Type, Print) nsula

State

Registrar

31. Date filed (Month

Dav. Year.

MAR 02 2012

Redistrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. FoAMEND#18 per FH State of Maryland / Department of Health and Mental Hygiene Certificate of Death Registrar 3/1/2012 AACO HEALTH DEPT Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 2 Physician/ Virginia 2012 Medical 4a. Facility Name (if not institution, give wreet and number, 4c. County of Death 4b. City, Town, or Location of Death **Examiner** McPherson Road Anne Arundel Annapolis Social Security Number 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) If Under 8. Date of Birth **Funeral** Days 5368649 Hours Min Director 1 🗆 M 2 🔽 03 05 28a-f show 10a. State 10b County 10c. City, Town or Location notified at Director MD ANNE ARUNDEL ANNAPOLIS 10e Street and Number 10f. Zip Code 0 10g. Citizen of What Country? items 23a or ner must be n Funeral US A 32 MCPHERSON ROAD 21401 death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian the Medical Examiner Armed Forces? Black, White, etc. 1 Never Married 2 Married ō \$ Maryland 21215-0036 72 hours after 1 Yes 2 No Specify. If Yes, Give Year or Dates "natural", 3 Widowed 4 Divorced Specify: Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) than " Elementary/Secondary (0-12) College (1-4 or 5+) 11 SECRETARY ELECTRICAL CONTRACTING and Mental Hygie is marked other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ JAMES CRAFT VEDA V. WALKER Richards Page 1 and 2 should I ment of Health and Me 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) If item 27 KATHY KLINGER/DAUGHTER 32 MCPHERSON ROAD ANNAPOLIS. MD 21401 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date Department of Important: If it any injury or o 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) HILLCREST MEMORIAL GARDENS /2/2012 ANNAPOLIS,MD 21. Signature of Funeral Service Liper FACILITY LASTING TRIBUTES FUNERAL CARE Name and Address of LFENBEIN & 4 BESTGATE ROAD ANNAPOLIS, MD23a Part 1. Enter the disea shock, or heart failure ast or completations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, List only one cause on each line. Immediate Cause (Final Physician/ disease or condition Medical resulting in death) uence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Cause (Disease or injury that initiated events resulting in death) Last burial-tran Due to (or as a con ding physician Physician/Medical that the death certificate be Box 68760 the use as IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months? Month Pregnant at time of death 5 Other (specify) 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>۾</u> Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an Hospital or Attending Physician: The law page 2 performed Division of Vital 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 PResidence 6 Other (Specify) 2 No 1 Tes ျှ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 5 Pending injury 1 Natural work? death. 2 No ☐ Accident Investigation in by the 24 hours after deat Funeral Director: 3 ☐ Suicide 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined completely filled Medical 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 To the F only one) 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) 10061321 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) modical PKWy Steleto Annapolis, mo 21401 MID bomra Souhine Date filed (Month, Day, Year) egistrar's Signatu State MAR 0 1 2012

3. Time of Death

9. Birthplace (State or Foreign

10d. Inside City Limits

Interval Between

Onset and Death

Day

1 ☐ Yes 2 ☐ No

2000 - Prosh

Year

1 Tes 2 No

PRINCETON WV

White

Year

DHMH 17 Rev 06-2011

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death February Physician/ 2012 Klein 2:45 Owings Harry Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death <u>Chesapeake Beach</u> 7736 Deforest Drive Calvert | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | 03-16-1925 Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 X M 2 □ F Months Mary Land **Director** 86 218-18-8561 Usual Residence of Decedent show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural" any injury or other traumatic event." 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits **Funeral Director** 1 X Yes 2 No Calvert Chesapeake Beach 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 7736 Deforest Drive 20732 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black, White, etc. Completed by 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify: 3 Widowed 4 Divorced Year or Dates. 1942–46 White 16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)
charter boat owner, captain 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) charter fishing 10 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Joseph Klein Harry Ella Mae Grierson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Allene Anne Klein, Spouse 7736 Deforest Drive, Chesapeake Beach, MD 20732 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 Durial 2 X Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metropolitan Crematory 02-28-12 Alexandria, VA Signature of Funeral Service Licensee 22. Name and Address of Facility Rausch Funeral Home, P.A. William R- War 8325 Mt. Harmony Lane, M00715 Owings, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ End disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events Due to (or as a consequence of) attending physician and for use as the burial-trar Due to (or as a consequence of): resulting in death) Last by Physician/Medical Hospital or Attending Physician; The law requires that the death certificate be Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 Fetal death Cother (specify) in the past 12 months? Day Pregnant at time of death 1 Yes 2 No 9 Unknown g 🗌 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Certificate: To Be Completed 1 Yes 2 No 3 Probably 4 Unknown Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed? 24 hours after death.

Funeral Director: After this certificate 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 2 KNo Other: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 2 Accident 5 \square Pending 1 Yes Investigation Could not be in by the 3 ☐ Suicide 4 ☐ Homicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 To the F 3 Certifying Nurse Practioner: Te the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 10+1 Jonathan Lowenthal, M.D., 110 Hospital Road, Suite 310, Prince Frederick, MD

DHMH 17 Rev 7/2009

State

Registrar

31. Date filed (Month, Day,

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 02 20/2 Medical 4a. Facility Name (if not institution, give street and number 4b. City, Town, or Location of Death 4c. County of Death Examiner ney Under 24 Hrs. Min. Montgomer Mad Star Montgomery Medical Center 8. Date of Birth Birthplace (State or Foreign Country) Funeral **Director** 295-32-6412 1 M 2 X F 80 1931 Usual Residence of Deceden May 12, Ohio 28a-f show er than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at 10a. State 10d. Inside City Limits 10b. County 10c. City, Town or Location Director 1 Yes 2X No Montgomery Rockville Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 4708 Norbeck Road 20853 United States death 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☒ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married þ Maryland 21215-0036 1 ☐ Yes 2 X No Specify. If Yes, Give Year or Dates Specify. 3 X Widowed 4 Divorced Completed White 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working should be filed within 72. In and Mental Hygiene. Is marked other than "r life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 4 Homemaker Own Home event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) permit. Page 1 and 2 should be Department of Health and Menta Important: If item 27 is marked any injury or com-ဂ္ဂ Mirrielees Spencer Hagen Retty 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 12109 Whippoorwill Lane, Rockville, Maryland 20852 J.P. Kelly/Son Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 🗷 Burial 2 🗆 Cremation 3 🗆 Removal from State cemetery, crematory or other place, 4 ☐ Donation 5 ☐ Other (Specify) 03/05/2012 | Silver Spring, MD. of Heaven Cem. 22. Name and Address of Facility DeVol Funeral Home 21. Signature of Funeral Service Licenses TRACUA Shive 40111 10 East Deer Park Dr., Gaithersburg, MD. 20877 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Obstructive Pulmonary Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) and Due to (or as a consequence of) physician a Physician/Medical requires that the death certificate be P.O. Box 68760 use as ding IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ atten for u in the past 12 months? Pregnant at time of death Month Day Year ed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part II. 23e. Did tobacco use contribute to the cause of death? þ been signe should be o 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records, Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an To the Hospital or Attending Physician: The law sate has l page 2 s autopsy performed After this certificate 1 Yes Yes 25. Was case referred to medica 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) ၉ 1 Yes 1 Inpatient 2 ER/Outpatient 3 I DOA funeral 27. Mann of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at work? 1 □ Yes 2 □ No 28d. Describe how injury occurred injury 1 Natural 5 Pending Accident
Suicide death. Investigation within 24 hours after death

To the Funeral Director. 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check

State Registrar only one)

ed (Month, Day, Year,

MAR 02 2012

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 06-2011

18101

29c. License number

60319

Prince Phillip Drive, Olney, Maryland 20832

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death KAZERMAN Physician/ 12.55AM **6** Medical 4a. Facility Name (if not institution, give street and number, **Examiner** . City. Town, or Location of Death 4c. County of Death Mandrin Inpatient Care Center Harwood Anne Arundel If Under 1 Year If Under 24 Hrs. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Social Security Number Days Min **Director** 212-64-4412 1 🗆 M 2 🗸 44 9/19/1967 Washington, DC ral", or items 23a or 28a-f show Examiner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits 72 hours after death with the Maryland Director Maryland 1 ☐ Yes 2 X No Anne Arundel Crownsville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1182 Gumbottom Road 21032 USA 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 X No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. "natural", or i by 1 Never Married 2 XMarried 1 Yes : Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: White 3 Divorced 4 Divorced Completed Year or Dates the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) than Elementary/Secondary (0-12) College (1-4 or 5+) and Mental Hygiene. Vice President of Sales Hotel Industry 4 years is marked other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Harold R. Fatzinger Meredith Lynn Department of Health and Important: If item 27 is n any injury or other traum. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Glen S. Kazerman/ Husband 1182 Gumbottom Road, Crownsville, MD 21032 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place, 1 X Burial 2 Cremation 3 Removal from State Baldwin Mem'l UMC Cemetery 3/2/12 Millersville, MD 4 Donation 5 Other (Specify) 22. Name and Address of Facility George P. Kalas Funeral Rome of Funeral Service Licensee 2973 Solomons Island Rd. Edgewater, MD 21037 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate BREAST Immediate Cause (Final ANCER Ph_sician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of) Exami To the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or injury that initiated events the burial-trai Due to (or as a consequence of): resulting in death) Last physician Physician/Medical Division of Vital Records, P.O. Box 68760 attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) ____ signed by the atter in the past 12 months? Pregnant at time of death 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Honknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2: autonsy 2 🗆 No 1 Yes B 25. Was case referred to medical 26. Place of Death (Check only one) Hospital Other: 2 No |은 1 Tyes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence After this nours after death.

neral Director: After this

filled in by the funeral d 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 Natural injury 5 Pending 1 Yes 2 No Accident Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined within 24 hours a

To the Funeral D

completely filled Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. dical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signa death (Item 23a) (Type, Print) ENSE HWY, MUNAPOLIS, M.D. 240)

Registrar
DHMH 17 Rev 06-2011

State

2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item s 1, per doc 8,18 per fh 9926 4-9-12 yt State of Maryland 7 Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Mary Ann Donohue Kornmeyer 3. Time of Death Month 03 Day OI Physician/ MAKYANNE 20 06 KOKNMEYER 2012 Medical 4a. Facility Name (if not institution, give street and number, 4b. City, Town, or Location of Death Examiner 4c. County of Death UNNERSITY OF MARKLAND WEDLINGENTER BATTMURE, If Under 1 Year If Under 24 Hrs. Social Security Number Age (In yrs. last birthday) 8. Date of Birth (Month, Da) (Year) 9. Birthplace (State or Foreign **Funeral** Days **Director** 155-32-0823 1 🗆 M 2 🗶 F PENNSYLVANIA JAN. 31, 1943 Usual Residence of Deced items 23a or 28a-f show her must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director CENTREVILLE **OUEEN ANNE'S** 1 X Yes 2 No MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 21617 848 HARMONY WAY 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes, 2 ☒ No
If Yes, Give
Year or Dates. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Examiner Black, White, etc. Ь ğ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 han "natural", e Medical Exan 1 ☐ Yes 2 X No Specify. 3 Widowed 4 Divorced WHITE Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) I Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) the LEGAL ADMINISTRATIVE ASSISTANT 2 should be filed with h and Mental Hygier 7 is marked other the 12 -0-Be 17. Father's Name (First, Middle, Last, 18. Mother's Name (First, Middle, Maiden Surname) ဂ CLAIRE BUSH MARK DONOHUE Clare Dolores Busch other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ge 1 and 2 short of Health a : If item 27 is 848 HARMONY WAY, CENTREVILLE, MD 21617 GEORGE E. KORNMEYER/HUSBAND 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1 Department of Important: If ii any injury or or 1 Burial 2 X Cremation 3 Removal from State MAR. CHESAPEAKE CREMATION STEVENSVILLE, MD 4 Donation 5 Other (Specify) 2012 21. Signature of F al ervice Licensee FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME, P.A. 408 S. LIBERTY ST., CENTREVILLE, MD 21617 23a. Part 1. Enter the disease, or complications that caused shock, or heart failure. List only one cause on each line. that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final Ph sician/ disease or condition ven traumatic Medical resulting in death) **Examiner** Sequentially list conditions, If any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) CERTIFICATION APPROVED BY MEDICAL EXAMINER Exam Hospital or Attending Physician: The law requires that the death certificate be executed and -trar Due to (or as a consequence of) resulting in death) Last physician Physician/Medical Division of Vital Records, P.O. Box 68760 the attending | IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Day Year Pregnant at time of death 1 Yes 2 No 9 Unknown the 9 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has pade 2 autopsy performed? 1 Yes 2 No 1 Yes 2 No 25. Was case referred to medica 26. Place of Death (Check only one) Be 1 Yes 2 No 1 MInpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: ᅆ 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at within 24 hours after death.

To the Funeral Director: After i completely filled in by the funer. 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending work? 1 ☐ Yes 2 No 02/29/2012 fell through attic Investigation Unknown Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 - Homicide City or Town, State) 848 HARMONYWAY, centrenile MO AT HOME Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d, Date signed (Month, Day, Year) MD 19223 03 011 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ASHIKA

State

Registrar

NATA

5 2012

31. Date filed (Month, Day, Year)

22

Greene St

Registrar's Signature

Baltimore, MM

12-01670

t in Black Indelible Ink Freure All Conies Are Legible

2-01670 hyllis Ann Lazar	้นร		of Maryland / De							0 0000
.,	1	- For State			te of Dea				201	2 08509
Physicia ledical Examin	n/	Registrar 1. Decedent's Name (First, Middle, Later Phyllis Ann Laza						2. Date of Deat Month February 2		3. Time of Death 0937 hrs
		4a. Facility Name (if not institution, given 1405 Mallard Point Road			, ,	, Town, or L	ocation of De		4c. County of Dear	h
Funeral		5. Social Security Number 6. S	ex 7. Age (In y	rs. last birth	nday) If Ur	nder 1 Year	If Under 24	Hrs. 8, Date of Bir	th(MM/DD/YYYY) 9. Bi	
Director			M 2XF 4	3	Yrs. Mor	iths Days	Hours N	08/22	/1968 Fore	ountry) GA
any		Usual Residence of Decedent 10a. State 10b. County	10c. (City. Town	or Location					10d. Inside City Limits
E		MD Calvert			e Frede	rick				1 Yes 2 X No
Aaryland 28a-f show 1 at once.	Director	10e. Street and Number				ip Code	_	1	ng. Citizen of What Co	intry?
th the Maryland 23a or 28a-f sho notified at once.		1405 Mallard Pos				.0678			United Sta	
ith wid	Funeral	11. Marital Status 1 Never Married 2 Married	d Armed Forces? If			 Was Decedent of Hispanic Origin? (Spe If Yes, specify Cuban, Mexican, Puerto R 			- 14. Race - Ame White, etc.	rican Indian, Black,
ter dez			1 Yes 2 X N d If Yes, Give Yaar or Dates:	lo :	1 Yes	2X No	specify:		Specify: Wh	nite
ours af atural	함	15. Decedent's Education (Specify of		d) 16a. [Decedent's Usu during most of v	al Occupati	on (Give kind	of work done	16b. Kind of Business	/Industry
more, MD 21215-0036 Pages I and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. ast: If item 27 is marked other than "natural", or items 23a or 28a-f she or other traumatic event, the Medical Examiner must be notified at once	Completed	Elementary/Secondary (0-12)	College (1-4 or 5+) 5+		man Res	_		,	Governme	
21215-0036 uld be filed within 7 Mental Hygiene, marked other thao	틹	17. Father's Name (First, Middle, Las	<u></u>	114				ame (First, Middle, I	Contract Maiden Surname)	<u>or </u>
21215-00; uld be filed with Mental Hygiene marked other ti	Be	Donald R. Escari	az					ra F. Swa		of Residence of the Control of the C
Baltimore, MD 21215, permit. Pages I and 2 should be filed Department of Health and Mental Hy Importact: If item 27 is marked of injury or other traumatic event, the		19a. Informant's Name/Relationship (100					nber, City or Town, Stat	
, MD ind 2 sho ealth and cm 27 is	-	Nichole Eskew /		Ob. Place o	TU Last of Disposition (N	lame of cerr	ver, A	Date	w Baden, I	r Town, State
Baltimore, permit. Pages 1 an Department of Hee Important: Titee		1 Burial 2 X Cremation 3	Removal from State	cremate	ory or other plac	ce)		2 /02 /2012	01:	MD
Itimit. Paratiment ortaot	ł	4 Donation 5 Other Specification 5 Donation 5 Donation 5 Donature of Pineral Service Lice	v: nsee	Lee	Cremato 22. Name a	ry nd Address	of Facility [ee Funera	Clinton, al Home Cal	vert, P.A.
Ban Dem Depin		Vary J. Goff			8200) Jenn	ifer L	ane, Owir	ngs, MD 207	36
Physician		23a. Part I. Enter the disease, or comfailure. List only one cause on e	each line.							Approximate Interval Between Onset and Death
ixaminer	1	Immediate Cause (Final disease or condition resulting in death)	Combined eff Due to (or as a consequent		of Morp	hine	and Me	thadone 1	oxicity	Deaul
	4	Sequentially list conditions,)							
. T.	iner	if any, leading to immediate cause. Enter underlying cause	Due to (or as a consequen	ce of):						
d Sit	Examiner	(Disease or injury that initiated events resulting in death) Last	Due to (or as a consequen	ce of):						
ox 68760, eath certificate be executed attending physician and for use as the burial - transit	ig B	X UNPENDED	. AMENDED 23a, 27	,28a-	f,per n	ne, g92	6 4-2-	12 sm		
60, ate be e hysicia e buria	Ned.	IF FEMALE:	23c. If yes, outcome of	_	-			-	23d. Date of delive	ny
687 certifica iding p	lan/	23b. Was decedent pregnant in the past 12 months?	1 Live birth Pregnant at time	ofdeath a			Ectopic pre	gnancy	Month	Day Year
Box 68760, e death certificate be the attending physic ed for use as the buried	Physician/Med	1 Yes 2 No 9 ✔ Unknow		ordeath 5	Other (S	pecity) _		***		
on of Vital Records, P.O. Box 68760, rediog Physiciae: The law requires that the death certificate be asth. or: After this certificate has been signed by the attending physicithe funeral director, page 2 should be detached for use as the burn		Part II. Other significant conditions	contributing to death but	not resulting	g in the underly	ing cause g	iven in Part I.		obacco use contribute t	o the cause of death?
ords, P.O. aw requires that the as been signed by the should be detached.	Completed by							24a. Was		autopsy findings available
of Vital Records, bg Physiciae: The law requir Wher this certificate has been s meral director, page 2 should la	nple							autor perfo	rmed? death?	
tal Reco		25. Was case referred to medical				26.Place	of Death (Che	1 Yes	2 No 1 🗸	fes 2 No
Vita ysicia ysicia his cer directe	8	examiner? 1 ✓ Yes 2 No	Hospital: 1 Inpatient 2	ER/O	utpatient 3	DOA	Other Nu	ırsing Home 5	Residence 6 🗸 Oth	er: Scene
n of Vi diog Physi After this funeral dir	Ë	27. Manner of Death 1 Natural 5 Pending	28a. Date of Injury (Month, Day, Year)		Time of Injury		y at Work? es 2 🗶 No	28d. Describe	how injury occurred	
5 5 5 5 5 5	catio	2 Accident Investiga	28e Place of Injury -		08:47 a	<u> </u>				Rural Route Number, City
Division spital or Attect hours after death foeral Director:	Certification:	3 Suicide 6 X Could no determin	of be		sidence	o. y, ooo		Rd. P	State)1405 Mal rince Frede	Rural Route Number, City Lard Point Prick,MD.
Hos 24 h Fuc		29a. Certifier 1 Certifying Physi	cian: To the best of my kno er:On the basis of examinat	wledge, dea	ath occurred at nvestigation, in	the time, da	ite and place, , death occurr	and due to the caused at the time, date	se(s) and manner as standard place, and due to	ated. the cause(s)
To the within To the comple	Medical	29b. Signature and title of certifier	and manner stated.			29c. Licens			29d. Date signed (M	
		Quet 2	<			O.C.I	M.E.		February 28, 20	012
		30. Name and address of person who			A/ Baltiman	Ctro-4	Politimore	MD 21222	<u> </u>	
	ate	31. Date filed (Month, Day Year)	ant Medical Examine 32. Registrar's Si		v. Dailimore	s sireet,	Daillinole,			
Regist		MAR -2	2012 anus	A.	bourse	A. Carrier				

DHMH 17 Rev 1/2001 OCME 2006

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 7 Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 2012 Wadde 11 Longus February 5:50 рм Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Silver Spring 14648 Tynewick Terrace Montgomery Social Security Number If Under 1 Year | If Under 24 Hrs. Age (In vrs. last birthday 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Hours 244-42-7361 Director 1 X M 2 D F 78 August 7, 1933 DC Usual Residence of Deced 28a-f show 10a. State 10b County 10c. City, Town or Location 10d. Inside City Limits with the Maryland Director notified 1 Yes 2 X No MD Silver Spring Montgomery 10e, Street and Number ō 10f. Zip Code 10g. Citizen of What Country? ms 23a or must be r Funeral 14648 Tynewick Terrace 20906 USA items Page 1 and 2 should be filed within 72 hours after death vent of Health and Mental Hygiene. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1952ģ 1 Never Married 2 Married "natural", or Baltimore, Maryland 21215-0036 If Yes, Give 1 Yes 21 No Specify. Specify: Black 3 Widowed 4X Divorced 1956 Completed Year or Dates Medical 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) other than " Elementary/Secondary (0-12) College (1-4 or 5+) Human Resources Federal Government Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) of Health and Mental H fitem 27 is marked ot r other traumatic ever ည John Scott Georgia Wooten 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Tracie A. Longus / Daughter 2036 Fourth Street, NW Washington, DC 20001 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State cemetery, crematory or other place ± 5 Department of Important: If any injury or Metropolitan CrematoryMarch 1, 2012 Alexandria, Virginia 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Francis J. Collins Funeral Home . Signature of Funeral Service Licenses 500 University Blvd. W, Silver Spring, MD 20901 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Ph_sician/ Lung Cancer disease or condition resulting in death) vears Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Exami 2 Hospital or Attending Physician: The law requires that the death certificate be executed and Due to (or as a consequence of) resulting in death) Last the burial attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ctopic pregnancy
5 Other (specify) o in the past 12 months? Day Month Year Pregnant at time of death signed by the at 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy performed? Yes 24 No this certificate 2 🛚 No 1 Tes Yes filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner?
1 Yes 2 X No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 24 hours after death. Funeral Director; After ⊼X_{Natural} 5 Pending work? 1 ☐ Yes 2 ☐ No Accident Investigation Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier 😾 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated within 2 only one Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title 2 29c. License number 29d. Date signed (Month, Day, Year) 10+1 D45880 February 29, 2012

Registrar
DHMH 17 Rev 06-2011

State

31. Date filed (Month, Day,

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Leon C. Hwang, 1396 Piccard Drive, Rockville, MD 20850

. Registrar's Sig

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death Physician/ March 2 Day 2012 Year 7:15p M Elizabeth Linley Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Montgomery Rockville Potomac Valley Nursing Home If Under 1 Year If Under 24 Hrs Social Security Number 7. Age (In vrs. last birthday) 8. Date of Birth g. Birthplace (State or Foreign **Funeral** Min. 1 D M 2 DX Hours 92 New Jersey 374-18-6305 Director Jsual Residence of Decedent ar than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director Rockville MD Montgomery 1X Yes 2 ☐ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20850 USA 1235 Potomac Valley Drive within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc þ 1 Never Married 2 Married Yes 2 No Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2x No Specify: White Specify: 3 XWidowed 4 Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) I Hygiene. Elementary/Seconday (0-12) 12 College (1-4 or 5+) Key Punch Operator Chrysler Corp. permit. Page 1 and 2 should be filed wi Department of Health and Mental Hygie Important: If item Z7 is marked other any injury or other treasm. Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Marie Lacyk Joseph Hodiak 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2804 Valley Drive Alexandria, Va. 22302 Robert Dyer/Nephew 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 🗆 Burial 2 🙀 Cremation 3 🗆 Reploval from State cemetery, crematory or other place) 3/3/2012 Beltsville, Md. Chesapeake Crem. 4 Donation 5 Other (Specify) Funeral Service Lice PHITTOP AT SERVICE, P.A. Columbia Blvd.Silver Spring, Md20910 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. interval Between Onset and Death Immediate Cause (Final Physician/ ocard disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions Examiner Due to (or as a consequence of). cause. Enter Underlying burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last nding physician and use as the burial-tran Due to (or as a consequence of): Physician/Medical requires that the death certificate be P.O. Box 68760 nse 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy atter in the past 12 months?

1 Yes 2 No
9 Unknown Por 5 Other (specify) Month Dav Year Pregnant at time of death signed by the a Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed should peen 24b. Were autopsy findings available prior to completion of cause of death? Ducease 24a Was an Physician: The law has page 2 s autopsy To the Hospital or Attending Physician: The within 24 hours after death.

To the Funeral Director: After this certificate 1 Yes 2 No 25. Was case referred to medical examiner?

1 Yes 2 No 26. Place of Death (Check only one) funeral director, Be Hospital မ 1 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Natural Certificate: 28d. Describe how injury occurred iniury 5 Pending work? 1 ☐ Yes 2 ☐ No Investigation Accident completed filled in by the 3 Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation in my action due to the cause(s) and manner as stated. Medical 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

Registrar

State

Shady Grove Court Gauthersby

Name and address of person who completed cause of death (Item 23a) (Type, Print)

MENDHIR

31. Date filed (Month, Day, Year,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Certificate of Death Registrar 1. Decedent's Name (First, Middle, Last) 2, Date of Death 3. Time of Death Evelyn Liebes S Physician/ 2^{Day}2012^{ear} March 9:50a м Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** #295 Montgomery Silver Spring 14508 Homecrest Road Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Hours 7/8/1922 057-18-7152 Brooklyn, N. Y **Director** 1 🗆 M 2 💢 F 89 Usual Residence of Decedent 28a-f shov 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits notified at with the Maryland Director Silver Spring 1 Yes 2 No MD Montgomery 10e Street and Number 10f. Zip Code ö 10g. Citizen of What Country? ms 23a or must be r Funeral 14508 Homecrest Road #205 20906 USA Page 1 and 2 should be filed within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) "natural", or item ledical Examiner r 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces Black, White, etc. þ 1 Never Married 2 Married Yes 2 X No Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 XNo Specify: Specify: White Completed 3 Widowed 4 Divorced the Medical Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) than College (1-4 or 5+) Elementary/Secondary (0-12) Administrative Office work ed other event, th Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname Department of Health and Mental I Important: If item 27 is marked o any injury or other traumatic eve Florence Schwartz ဥ Louis Schonfeld 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)2090619a. Informant's Name/Relationship (Type, Print) Harold Liebes/Husband 14508 Homecrest Road #205 Silver Spring, MD 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 X Burial 2 Cremation 3 X Removal from State 3/5/2012 Rochelle Park, N.J. Riverside Cem. 5 Other (Specify) 4 Donation PHILIPADES RINALDI FUNERAL SERVICE, P.A. 21. Signature of 9241 Columbia Blvd.Silver Spring, Md20910 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Ph, sician Ongestive Heart disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of) the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) attending physician for use as the burial Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 Yes 2 No Month Day Year Pregnant at time of death been signed by the s should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy performed? Yes 2 X No After this certificate has funeral director, page 2 2 🗌 No 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 \square Nursing Home 5 \bigcirc Residence 6 \square Other (Specify) ဂ္ဂ 1 Yes 2 X No 1 Inpatient 2 ER/Outpatient 3 IDOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending injury work? 1 ☐ Yes 2 ☐ No Accident Investigation 24 hours after death Funeral Director. filled in by the 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 😾 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

Registrar DHMH 17 Rev 06-2011

State

within 2 To the F

29a. Certifier

(Check

only one) 29b. Signature And title of certifie

elor

31. Date filed (Month, Day, Year)

Peter Sherer M.D.

MAR 0 5 2012

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Ferrara

mo

3921

32. Registrar's Signature

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29d. Date signed (Month, Day, Year March 2,2012

Silver Spring, Md 20906

29c. License number

Drive

12-01386 Crystal Lunsford Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Diyətai Lulisibiu	1- For State Registrar Certificate C		Reg. No. 201	2 0851
Physician/ Medical Examiner	Decedent's Name (First, Middle, Last)		2. Date of Death Month Day Year February 16, 2012	3. Time of Death 0545 hrs
	4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death	l
Funeral	Harford Memorial Hospital 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	Havre de Grace If Under 1 Year If Under 24Hrs		
Director	217-15-3034 1_M 2XF 37 Y	Months Days Hours Min	Feb 16,1975 co	on untry) PA
any	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Local			10d. Inside City Limits
yland a-f show t once.	MD Cecil Rising S	Un Tof, Zip Code	10g. Citizen of What Cour	1 Yes 2 No
h the Maryland 3a or 28a-f sh notified at once		21911	USA	
more, MD 21215-0036 Pages I and 2 should be filed within 72 hours after death with the Maryland tent of Health and Mental Hygiene. Int: If item 27 is marked other than "matural", or items 23s or 28s-f also or other traumatic event, the Medical Examiner must be notified at once. To Be Completed by Funeral Director		as Decedent of Hispanic Origin? (Sy Yes, specify Cuban, Mexican, Puerto Yes 2 X No specify:	Rican, etc.) White, etc.	ican Indian, Black,
ours after attention of the same of the sa	l or Dates:	nt's Usual Decupation (Give kind of vectors of working life. DO NOT use reti	work done 16b. Kind of Business/	Industry
, MD 21215-0036 and 2 should be filed within 72 hours after teath and Mental Hygene. tem 27 is marked other than "natural", traumatic event, the Medical Examiner To Be Completed by I	Elementary/Secondary (0-12)	maker	Own Home	<u>.</u>
21215-0036 uld be filed within 7 Mental Hygiene. marked other than cevent, the Medica			(First, Middle, Maiden Surname)	
2121 ould be fil ould be fil o	William Warren Hensel, Sr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailin		line Ann Kellenb Rural Route Number, City or Town, State	
, MD and 2 sho saith and cm 27 is resument:	1	Spring Hill Ro	L. Rising Sun, M. Date 20c. Location - City or	
Baltimore, permit. Pages 1 ar Department of Hee Important: If ite		d Funeral Home	20/12 Rising	Sun, MD
Baltimore, MD 21215 permit. Pages I and 2 should be filed Department of Health and Mental Hy Important: If item 27 is marked o injury or other traumatic event, it To Be C	21. Signature of Funeral Service Light see	Name and Address of Eacility T. Foard Fune	eral Home, P.A. Rising Sun, MD	21911
Physician /Megical	23a. Part I. Enter the disease, or complications that caused the death. Do not enter failure. List only the cause on each line.	the mode of dying, such as cardiac of	r respiratory arrest, shock, or heart	Approximate Interval Between Onset and
Examiner	Immediate Cau (Final disease or condition soulting in death) a. ullmonary Thromboembolism Due to (or as a consequence of):			Death
6	Sequentially list conditions, if any leading to immediate			
amin	if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): d. UNPENDED IF FEMALE: 23b. Was decedent pregnant in the			
ecuted and transit	d.			
60, ate be ex hysiciar e burial	UNPENDED AMENDED IF FEMALE: 23c. If yes, outcome of pregnancy		23d. Date of deliver	<u> </u>
Division of Vital Records, P.O. Box 68760, To the Bospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the artending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit edical Certification: To Be Completed by Physician/Medical Ex	23b. Was decedent pregnant in the past 12 months? 1 ☐ Live birth 4 ☐ Pregnant at time of death 5 ☐ 0 9 ☐ Unknown	etal death 3 Ectopic pregna Other (Specify)	Month (Day Year
P.O. B s that the d gned by the detached by Phy		underlying cause given in Part I.	23e. Did tobacco use contribute to	
ds, P equires t een sign ould be d			24a, Was an 24b. Were au	bably 4 Unknown utopsy findings available
Records, The law requires ficate has been sign, page 2 should be Completed			autopsy prior to death? 1 ✓ Yes 2 No 1 ✓ Yes	completion of cause of
Ital Rician: Tician: Tician: Estor, p	examiner?	26.Place of Death (Check	only one)	
of Vi ig Physi fler this neral dir	1 Yes 2 No 1 Inpatient 2 PROutpatient 27 Message of Double		ng Home 5 Residence 6 Othe 28d. Describe how injury occurred	r.
Sion Attendin death. ctor: A y the fu	1 V Natural 5 Pending 2 Accident Investigation	1 Yes 2 No	206 Location (Street and Number of D.	and Double Number City
Division ospital or Attending hours after death. Beral Director: After filled in by the function of filled in by the function:	3 Suicide 6 Could not be determined (Specify)	eet, ractory, onice building, etc.	28f. Location (Street and Number or Ru or Town, State)	arai Roule Number, Oily
Division of Vital Records, P To the Bospital or Attending Physician: The law requires to within 24 hours after death. To the Funeral Director: After this certificate has been sign completely filled in by the funeral director, page 2 should be Medical Certification: To Be Completed the second page 2.				
To ror	and manner stated. 29b. Signature and title of certifier	29c. License number	29d. Date signed (Mo	
	30. Name and address of person who completed pause of death (Item 23a)	O.C.M.E. OCA	AE February 17, 20°	12
3	Theodore M. King, Jr., MD. Assistant Medical Examiner	900 W. Baltimore Street, E	altimore, MD 21223	<u> </u>
State Registrar		a del		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ M031 01 2012 5:45 Donald James Milliken аМ Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City. Town, or Location of Death 4c. County of Death 9700 Tam O'Shanter Drive Prince Georges Upper Marlboro Social Security Number If Under If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country)
 OU Age (In vrs. last birthday **Funeral** Hours 1 X M 2 □ F Month 0470471934 Director 300-30-6223 OH Usual Residence of Decedent 28a-f show 10a. State 10b. County notified at 10c. City. Town or Location 10d. Inside City Limits Director 1 Yes 2 X No Prince Georges Upper Marlboro MD 10e. Street and Number ö 10f. Zip Code 10g. Citizen of What Country? "natural", or items 23a or Funeral 9700 Tam O'Shanter Drive 20772 United States 72 hours after death 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, rmed Forces?

X Yes 2 □ No Black, White, etc. 1 Never Married 2 X Married þ Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify. 3 Widowed 4 Divorced Specify: Completed White the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working and Mental Hygiene. life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 5+ Career Military U. S. Air Force Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, Department of Health and Should be Department of Health and Menta Important: If item 27 is marked any injury or other traumatin conce. မ Edward C. Milliken Vera Clare Shull 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9700 Tam O'Shanter Drive, Upper Marlboro, MD 20772 Wilda Carol Milliken / Wife 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 K Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Maryland Veterans Cemetery 03/07/2012 Cheltenham, MD 22. Name and Address of Facility Lee Funeral Home Calvert, P.A. 21. Signature of Fundal Service Licensee Garo J. Gori 8200 Jennifer Lane, Owings, MD 20736 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Ph sician MULTI ORGAN WZ disease or condition Medical resulting in death) Due to (or as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed burial-transit and Due to (or as a consequence of): resulting in death) Last attending physician for use as the buria Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month 5 Other (specify) Pregnant at time of death signed by the a Yes 2 No 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed Were autopsy findings available prior to completion of cause of 24a. Was an page 2 s autopsy perform certificate 1 Yes 2 No 1 Yes 2 No 25. Was case referred to medical director, Be 26. Place of Death (Check only one) examiner? 12 Other 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 X Residence 6 Other (Specify) After this funeral dir 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate; 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending nours at er death.

neral Director. Aft
filled is by the fur 1 🗌 Yes 2 🗌 No Accident Investigation Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 24 hours a Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. completed (Check Certifying Nurse Practioner: To the best of my knowledge, death or

tru State

within 7

Registrar

29b. Signature

30. Name and address o

31. Date filed (Month, Day, Year

MINT

nd title of certifier

pleted cause of death (Item 23a) (Type, Print)

ed at the time, date and place, and due to the cause(s) and manner as stated.

		State Registrar		Cer	tificate of D	eath		Reg. No	2017	2.08515
Physicia		Decedent's Name (First, Middle, Last) Joan	More	gan			2. Date of De		^{ay} 2012 ^y ear	3. Time of Death 8:35a M
Medic Examin		4a. Facility Name (if not institution, give stre			4b. City, Town, or	Location of Death	1	40	County of Deat	
Funeral Director		5. Social Security Number 6. Sex	7. Age (In yrs. I	**	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da	ay, Year)	9. Bir Co	thplace (State or Foreign untry)
aryland ia-f show ified at	ector	Usual Residence of Decedent 10a. State 10b. County MD Montgome	l l	y, Town or Loc			1.07.07		· .	10d. Inside City Limits 1 ☐ Yes 2 No
with the M s 23a or 28 lust be not	by Funeral Director	10e. Street and Number 21821 Big Woods	s Road		10f. Zip Code 208	42		10g. Ci	tizen of What Co	ountry?
permit. Page 1 and 2 should be filed within 72 hours after death with the Manyland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amportant: If item 27 is marked other than "natural", or items 23a or 28a-f show amportant: If item 27 is marked other than "matural", or items 23a or 28a-f show amportant it items 23a or 28a-f show amportant in a superior in a sup	d by Fur	11. Marital Status 12 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☑ Divorced	. Was Decedent Ever in U. Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates.	"	Vas Decedent of His Yes, specify Cubar ☐ Yes 2 🙀 No	n, Mexican, Puerto	pecify Yes or No- o Rican, etc.)		14. Race - Ame Black, White Specify:	
hin 72 hour ne. than "natur te Medical I	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)	ation completed) College (1-4 or 5+)	(Give F	lent's Usual Occupa kind of work done do NOT use retired) Bookkeep	uring most of wor	king		and of Business	
I be filed wit lental Hygie rked other tic event, th	To Be C	17. Father's Name (First, Middle, Last) Ralph Rosenber	ger		JOOKREED	18. Mother's Nan Ruth	ne (First, Middle, Young			
nd 2 should salth and M n 27 is mai er traumat		19a. Informant's Name/Relationship (Type, Sarah Welch/Dan	Print) ughter	19b. Mailin 218	g Address (Street a	nd Number or Rui Woods I	ral Route Numbe	r, City or I CK 6	Town, State, Zin	id 20842
i. Page 1 ar tment of He tant: If iter ijury or oth	20a. Method of Disposition 1 Burial 2 Genation 3 Removal from State 4 Donation									
permit Depar Impor any in		21. Signature of Vineral Service Licersel	undel		HTLTP ^{dd} D° 241 Coli	RTWALD umbia B	I FUNE	RAL lve	SERVI r Spri	CE,P.A. ng,Md20910
Physician/ Medical		23a. Part 1. Enter the disease, or complic shock, or heart failure. List only one of the classes of condition resulting in death)		rs Dir		, such as cardiac	or respiratory a	rrest,		Approximate Interval Between Onset and Death
Examiner and	xaminer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events c.	Due to (or as a consequence)	uence of):						
		resulting in death) Last	Due to (or as a consequence	uence of):		-				
To the Hospital or Attending Physician: The law requires that the death certificate be exe within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician a To the Funeral Director. After this certificate has been signed by the attending physician and the properties of the funeral director, page 2 should be detached for use as the burial or the funeral director, page 2 should be detached for use as the burial contents.	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	t. If yes, outcome of pregnation 1 Live Birth 2 Feta 4 Pregnant at time of g Unknown	aldeath 3	Ectopic pregnancy Other (specify)	/			23d. Date of de Month	livery Day Year
es that the igned by be deta	b	Part II. Other significant conditions control	ibuting to death but not res	sulting in the u	nderlying cause giv	en in Part I.				the cause of death?
re law requir e has been s age 2 should	Completed	Lung cancer					24a. Was auto perfe	an opsy ormed?	24b. Were au prior to death?	topsy findings available completion of cause of
cian: The sertificat ector, pa	Be	25. Was case referred to medical examiner?	spital:			ice of Death (Ched				s 2 🗆 No
nding Physi ath. :: After this c e funeral dir	cate: To	1	1 Inpatient 2 28a. Date of injury (Month, Day, Year)	ER/Outpatien 28b. Time of injury	28c. Injury work	4 □ Nursing H at	ome 5 Resi 28d. Describe			ify) hospice
ital or Atte irs after deg al Director led in by th	al Certificate:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Hornicide determined	28e. Place of Injury - At ho building, etc. (Specify	ome, farm, stre	eet, factory, office	• •	28f. Location (City or To			ral Route Number,
te Hosp n 24 hot te Funer sletely fil	Medical	(Check 2, Medical Examiner	an: To the best of my know : On the basis of examinatio Practitioner: To the best of r	n and/or invest	igation, in my opinio	n, death occurred a	at the time, date	and place	e, and due to the	cause(s) and manner stated
athir #	2	29b. Signature and title of certifier	8	,	29c. License	number			ite signed (Monti	

Registrar

DHMH 17 Rev 06-2011

State

31. Date filed (Month, Day, Year)

.eest

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			For State Registrar	State of Marylar		artment of H tificate of D			giene Reg. No. 2	112 08516
ì	Physicia		1. Decedent's Name (First, Middle, Last) Elizabeth	5.		Mart	rin	2. Date of Dea Month 2		Year 2012 8:15 a M
	Medic Examin		4a. Facility Name (if not institution, give st. Medstar Montgomery		or	4b. City, Town, or Olney	Location of Deatl	1	4c. County	
	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs.	last birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birtl	h	g. Birthplace (State or Foreign Country)
	Director		Usual Residence of Decedent	М 2 🖾 F 9 5				May 18	, 1916	Maryland
	aryland a-f sho fied at	Director	10a. State 10b. County		ty, Town or Lo					10d. Inside City Limits 1 ☐ Yes 2 ☑ No
	the Main or 28	Dire	Maryland Montgome: 10e. Street and Number	ry 513	lver Sp	10f. Zip Code			10g. Citizen of \	
	th with ms 23a must b	Funeral	460 Ednor Road		- L.	20905			USA	
21215-0036	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	by	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	2. Was Decedent Ever in U. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates.	1	Was Decedent of His f Yes, specify Cubar	n, Mexican, Puert	o Rican, etc.)		e - American Indian, ck, White, etc. · White
15-(72 hou in "nati Medica	Completed	15. Decedent's Edu (Specify only highest grade	e completed)	(Give I	dent's Usual Occupa kind of work done di O NOT use retired)		king	16b. Kind of B	usiness/Industry
212	I within ygiene. her tha it, the I		Elementary/Secondary (0-12)	College (1-4 or 5+)	Homem				Own Hor	me
Baltimore, Maryland	be filed ental H rked ot ic ever	To Be	17. Father's Name (First, Middle, Last) Leroy Marshal Smit!	h				ne <i>(First, Middle, i</i> a rie Buc]		e)
lary	should and M is mar		19a. Informant's Name/Relationship (Type		24	ng Address (Street a				
e, N	and 2 Health tem 27		Kathleen Clancy / I 20a. Method of Disposition			Old Liber	ty Road	Sykesv:		D 21784 - City or Town, State
mor	Page 1 nent of ant: If it		1 X Burial 2 ☐ Cremation 3 ☐ R 4 ☐ Donation 5 ☐ Other (Specify)	emoval from State	cemetery, cren	natory or other place leaven Ceπ	: 114	cch 5.		Spring, MD
Balt	permit. Departr Import any inji		21. Signature of Funeral Service Licenses		17	rancard Addres	s of a liting	Funera	l Home, Silver	Inc. Spring, MD 2090
23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death										
-/** <u>.</u>	Medical		disease or condition resulting in death)	Due to (o as a conseq		Faile				
	Examiner	e	Sequentially list conditions, b	ASPIRA Dye to (or as a conseq	tion	bue	umo	nia		
	uted ansit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events		100	a				
_	cate be executed physician and street transitions the burial-transitions.		resulting in death) Last	Due to (or as a conseq Acute	uence of):	al Fo	allur	P		
68760	ficate b g physi as the	Medical	d	1 Care	1 011				1	
. Box 68	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/N	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 No g ☐ Unknown	3c. If yes, outcome of pregna 1 ☐ Live Birth 2 ☐ Fet 4 ☐ Pregnant at time of g ☐ Unknown	al death 3	Ectopic pregnancy Other (specify)	У			ate of delivery onth Day Year
P.O.	s that the gned by be deta	by	Part II. Other significant conditions conf	tributing to death but not res	sulting in the u	inderlying cause give	en in Part 1.			ribute to the cause of death?
ords,	require been si should	eted						1 🔲)		3 Probably 4 Unknown Were autopsy findings available
Reco	n: The law ficate has l or, page 2 s	Completed	25. Was case referred to medical					autop perfoi 1 🗆 Yes	med?	death?
Vita	nysicial iis certi directo	To Be	examiner?	ospital: 1 Inpatient 2	ER/Outpatier	Otho	r: 4 Nursing F	lome 5 \square Resid	ence 6 🗆 Othe	er (Specify)
Division of Vital Records,	tending Pt death. tor; Affer th the funeral	Certificate:	27. Manner of Death 1 Natural 5 Pending 2 Accident Investigation 3 Suicide 6 Could not be	28a. Date of injury (Month, Day, Year)	28b. Time of injury	M 1 □	at ? Yes 2 🗆 No	28d. Describe h	ow injury occurr	ed
Divis	oital or At ours after o eral Direct	al Cert	4 Homicide determined	28e. Place of Injury - At he building, etc. (Specif	y)			City or Tow	n, State)	er or Rural Route Number,
	ne Hos in 24 hc ne Fune pletely	Medical	(Check 2 Medical Examine	ian: To the best of my know on the basis of examination Practitioner: To the best of	n and/or invest	tigation, in my opinior	n, death occurred	at the time, date ar	nd place, and due	e to the cause(s) and manner stated.
	vithii Comp	_	29b. Signature and title of certific	2		29c. License	number			d (Month, Day, Year)
			30. Name and address of person who cor	npleted caused death (Iter	n 23a) (Type, P	Print) 18101 P	rince Ph	nilip Dr	., Olney	y, MD 20832
	Stat Registra	e	31. Date filed (Month, Day, Year) MAR 0 2 2012	32. Registrar's Signa	ature back	w.				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Christy Francis Merrbach 201 10:45 March Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Montgomery Holy Cross Hospital Silver Spring 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign Funeral Days Hours (Month, Day, Year) 92 577-38-8518 Director 1 🖾 M 2 🗆 F 1919 PA Sep 21, Usual Residence of Decedent shov 10b. County 10c. City, Town or Location 10d. Inside City Limits with the Maryland must be notified at Director 28a-f 1 Yes 2 K No MD Montgomery Silver Spring 0 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23aFuneral 10502 Hayes Avenue 20902 USA ural", or items ? I Examiner mus death 12. Was Decedent Ever in U.S.
Armed Forces?

1 X Yes 2 No 1941If Yes, Give 1945 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Page 1 and 2 should be filed within 72 hours after 1 ☐ Yes 2 🗷 No Specify: 3X Widowed 4 □ Divorced 1945 Specify: "natural" Completed White Year or Dates the Medical Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Mechanic Automobile event, 1 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, Department of Health and Mental I Important: If item 27 is marked o any injury or other traumatic eve ၉ Christopher Merrbach Minni Katherine Spiker 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 10502 Hayes Avenue Silver Spring, MD 20902 Robert Merrbach / Son 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Parklawn Memorial Park Park 1 🔀 Burial 2 🗌 Cremation 3 🗌 Removal from State Mar 4, 2012 Rockville, MD 4 Donation 5 Other (Specify) 22. Name and Address of Facility Francis J. Collins Funeral Home Inc. uneral Service Licenses 500 University Blvd. W, Silver Spring, MD 20901 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Sepsis disease or condition resulting in death) Medical Due to (or as a consequence of): **Examiner** Pneumonia Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlyin Cause (Disease or injury Due to (or as a consequence of): and in and To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director; After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial to the completely filled in by the funeral director, page 2 should be detached for use as the burial to the completely filled in by the funeral director. Respiratory Failure that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Other (specify) Pregnant at time of death g Unknown 9 I Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Hypertension 2 No 3 ☐ Probably 4 ☐ Unknown 1 Yes 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 X No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital 1 ☐ Yes 2 🖾 No မ 1 K Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at work? 28d. Describe how injury occurred 1 🔀 Natural iniury 5 Pending 1 ☐ Yes 2 ☐ No ☐ Accident Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar

DHMH 17 Rev 06-2011

31. Date filed (Month, Day, Year)

MAR 0 5 2012

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Kshama Garg, 13332 Deerbrook Drive, Potomac, MD 20854

32. Registrar's Signature

D60826

March 2, 2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
 Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Physician/ 9:13 P M February 2012 Mary Lou Mohler Medical 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) 4c. County of Death **Examiner** Frederick Rocky Ridge 9422 Old Mill Road 8. Date of Birth (Month, Day, Year) April 29, 1955 Maryland If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Hours 212-62-3056 56 1 🗆 M 2 🖺 F **Director** Usual Residence of Decedent ms 23a or 28a-f show must be notified at 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location with the Maryland Director Frederick Maryland Rocky Ridge 1 Yes 2 X No 10g. Citizen of What Country? 10f. Zip Code 0e. Street and Number USA by Funeral 21788 9422 Old Mill Road "natural", or items within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 Yes 2 No white Baltimore, Maryland 21215-0036 1 Yes 2X No Specify: 3 Widowed 4 Divorced Completed Year or Dates Hygiene.

other than "natur.
rent, the Medical E 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4 or 5+) Elementary/Secondary (0-12) own home 12 Homemaker is marked other Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) permit. Page 1 and 2 should be file Department of Heath and Mental Important: If item 27 is marked o any injuy or other traumatic eve once. Mentail ပ Betty Ann Burrier Lester Lamar Poole, Sr. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9422 Old Mill Road, Rocky Ridge, Maryland 21788 19a. Informant's Name/Relationship (Type, Print) Robert Mohler - husband 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition Date 1 Burial 2 Cremation 3 Removal from State Stauffer Crematory 2-28-2012 Frederick, Maryland 4 Donation 5 Other (Specify) 22. Name and Address of Facility 21. Sign ture of Funeral Service Ricensee Stauffer Funeral Home 21702 1621 Opossumtown Pike, Frederick, Maryland lue 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final disease or condition resulting in death) bstructive Physician/ 0 sacs hronic Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to for as a consequence of Cause (Disease or injury the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) physician Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 use as ding 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy jo in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) Pregnant at time of death the. Unknown ģ 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. signed I by 1 Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy performe 1 ☐ Yes 2 ☐ No certificate 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 100 1 Inpatient 2 ER/Outpatient 3 DOA 1 Yes ည this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Certificate: within 24 hours after death.

To the Funeral Director: After of completely filled in by the funer injury work? 1 ☐ Yes 2 ☐ No 5 Pending Natural Investigation Accident Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suiciae 4 ☐ Homicide determined Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated | Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 3 🗌

State

29b. Signature and title of

31. Date filed (Month, Day, Year)

Gene F. Ashe, M.D.

MAR

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

Registrar

DHMH 17 Rev 06-2011

29c. License numbe

MDD31058

10200 Coppermine Road, Woodsboro, Maryland

29d. Date signed (Month, Day, Year)

February 23, 2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 590 M Robin Lucinda Millberry Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Carroll Westminster Carroll Hospital Center If Under 1 Year | If Under 24 Hrs. 8 Date of Birth Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) **Funeral** Hours (Month, Day, Year) 218-54-1219 Director 1 □ M 2X F 59 04/16/1952 MD 28a-f show 10c. City, Town or Location 10d. Inside City Limits Examiner must be notified at Director 1 X Yes 2 No MD Carroll Westminster 10 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? items 23a Funeral USA 52 Hillside Court 21157 12. Was Decedent Ever in U.S. Armed Forces?
1 Yes 2 No
If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black White etc or i þ 1 Never Married 2 X Married Maryland 21215-0036 1 ☐ Yes 2 No Specify: 3 Widowed 4 Divorced Specify: Black than "natural", Completed Year or Dates other traumatic event, the Medical 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Coil Finisher Gould/Telemechanique marked other 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Carolyn Brightful Pius Cooper 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 st Department of Health a Important: If item 27 is any injury or other tra 52 Hillside Court, Westminster, MD Douglas L. Millberry/husband Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2X Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 03/19/2012 | Hampstead, MD Carroll Cremation 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Pritts Funeral Home and Chapel 412 Washington Road, Westminster, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. RHEUMATIC HEART DISEASE Immediate Cause (Final Ph sician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions Due to lor as a consequence of cause. Enter Underlying Exami death certificate be executed Cause (Disease or injury sician and burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) nding physician ause as the burial Physician/Medical Box 68760 use a 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) atter for u in the past 12 months?

1 Yes 2 No
9 Unknown Dav Pregnant at time of death P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

ATRIAL FIBRILLATION signed I 23e. Did tobacco use contribute to the cause of death? ģ 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records, Completed LEFT RENAL THUR 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an ate has page 2 s DIABETES MELLITUS 1 Yes 2 No 1 ☐ Yes 2 ☐ No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify, 2 🗹 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred 1 Natural
2 Accident
3 Suicide
4 Homicide 5 🗀 Pending Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29d. Date signed (Month, Day, Year)

8 Ch State

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29b. Signature and title of certifier

Dr. Francis Khoo, 200 Memorial Avenue, Westminster, MD

MAR 1 9 2012

Registrar

3-11-12

21157

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. end #3 Per PHY G925 3/19/2012 In State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 2012 3. Time of Death Physician/ February 18, Dorothy Reatha Nickle 8:25 а м Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Harford Harford Memorial Hospital Havre de Grace Social Security Number 7. Age (In yrs. last birthdav) If Under 1 Year If Under 24 Hrs. 6. Sex 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 M 2 K Feb. 20, 1920 Hours Country) Mary1and **Director** 91 218-26-7107 Usual Residence of Decedent Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Heath and Mental Hygiene. In the marked other than "natural", or items 23a or 28a-f show ury or other traumatic event, the Medical Examiner must be notified at 10a. State 10h County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No Perryville Maryland Cecil 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21903 U.S.A. 298 Jackson Station Road 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc 1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: White Specify: 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b, Kind of Business Industry (Specify only highest grade completed) Hill Top Ranch Elementary/Seconday (0-12) College (1-4 or 5+) Colora, Maryland Food Services Six Years Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Edgar McCummins Annie E. Barrow 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 Homestead Drive, Port Deposit, Maryland 21904 Dorothy Bryant (daughter) 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State permit. Page 1 a
Department of H
Important: If ite
any injury or ot cemetery, crematory or other place) Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) North East Cemetery ! 02/22/12 North East, Maryland Signature of Funeral Service Licensee 22. Name and Address of Facility Lee A. Patterson & Son Funeral Home, P.A. 21903-0766 Perryville, Maryland 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, Examiner Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying attending physician and for use as the burial-transit the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury that initiated events resulting in death) Last by Physician/Medical 10 Division of Vital Records, P.O. Box 68760 IF FEMALE: es, outcome of pregnancy Live Birth 2 🗆 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Day Pregnant at time of death 5 Other (specify) 2 X No the 1 ☐ Yes 2 ☑ 9 ☐ Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🕅 Unknown Completed within 24 hours after death. To the Funeral Director: After this certificate has been 24b. Were autopsy findings available 24a Was an prior to completion of cause of death? yes 2 2 🕅 No 1 Yes 25. Was case referred to medical funeral director, 26. Place of Death (Check only one) Be examiner? Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 X No 1 🗌 Yes ဂ္ 1 XInpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death Certificate: 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending (Month, Day, Year) Natural work 1 Yes 2 No Accident Investigation Suicide 6 Could not be 3 ☐ Suícide 4 ☐ Homicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined Medical 🗵 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar SAchder

31. Date filed (Month, Day, Year)

32. Registrar's Signature

East Md 21901

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death I. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 0223 2 20/2 Medical 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) 4c. County of Death Examiner Ve DALWO 2000 Komer & Cr055 1 If Under 1 Year If Under 24 Hrs. 8. Date of Birth 6 Sex Age (In yrs. last birthday) 9. Difthplace (State or Foreign **Funeral** Months Hours Min (Month. Day, Year, 622-64-0291 Director 1 **X** M 2 □ F Yrs. 62 09/29/1949 Ethiopia Usual Residence of Decede 28a-f show 10b. County 10d. Inside City Limits with the Maryland 10a, State 10c. City, Town or Location notified at Director 1 Yes 2 X No Maryland Burtonsville Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? o r than "natural", or items 23a or the Medical Examiner must be Funeral 3705 Berleigh Hill Court 20866 U.S.A. death v Was Decedent of Hispanic Origin? (Specity Yes or No-If Yes, specity Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 14 Bace - American Indian 11. Marital Status Armed Forces? African-American 1 X Never Married 2 Married þ Maryland 21215-0036 72 hours after 1 ☐ Yes 2 K No Specify: If Yes, Give Year or Dates Completed 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) Engineering Senior Inspector Be 17 Father's Name (First Middle Last 18. Mother's Name (First, Middle, Maiden Surname) 2 Negatu Beshah Roman Dekau 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important; If item 27 is any injury or other trauonce. Daniel Negatu - Brother 664 Ross Road, Columbus, Ohio 43213 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place, 20a. Method of Disposition 20c. Location - City or Town, State Date 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) George Washington Cem 03/03/2012 Adelphi, Maryland 22. Name and Address of Facility Hines-Rinaldi Funeral Home, M1564 11800 New Hampshire Ave., Silver Spring, MD 20904 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph_sician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): Cause (Disease or injury that initiated events resulting in death) Last To the Hospital or Attending Physician; The law requires that the death certificate be executed Due to (or as a consequence of): nding physician ause as the burial Physician/Medical Box 68760 use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No jo Day Month Yea Pregnant at time of death the a P.O. ed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? signed b by 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records, plnods Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy performed? Yes 2 No certificate 2 No 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 \(\sum \) Nursing Home 5 \(\sum \) Residence 6 \(\sum \) Other (Specify) 2 No 1 ☐ Inpatient 2 XER/Outpatient 3 ☐ DOA ၉ this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director: After of completely filled in by the funer 1 Natural 5 Pending Accident Investigation 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one)

State Registrar

10

29h.

Signature and title of certific

31. Date filed (Month, Day, Year)

MAR 02

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) EGH

52

Registrar's Signature

29c. License number

004

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death eurge W. O'Connor Physician/ Month 12:00 AM 2012 Medical February 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Arnold Anne Arundel FutureCare Chesapeake Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Social Security Number 7. Age (In vrs. last birthday Funeral Days Hours Min (Month, Day, Year) 140-14-8894 Director 89 1 😾 M 2 🗆 F 30,1922 New Jersey Nov. show ms 23a or 28a-f sho must be notified at 10c. City, Town or Location 10d. Inside City Limits Director MD Anne Arundel Arnold 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 305 College Parkway 21012 USA ral", or items ? Examiner mus 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) death 12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 \(\square\) No 14. Race - American Indian, Black, White, etc. ò 1 Never Married 2 Married Page 1 and 2 should be filed within 72 hours after 1 X Yes If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ▼ No Specify White "natural", Specify Completed 3 X Widowed 4 □ Divorced Year or Dates Medical 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Me Elementary/Secondary (0-12) College (1-4 or 5+) U.S. Navy Cryptologist Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Thomas O'Connor Ella Frances Wright 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Donna Stidham / Daughter 1501 Broadneck Place Condo # 402 Annapolis, MD21409 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State March 02, Place of Disposition (1987)
Baltimore Norther place
Cemetery X Burial 2 Cremation 3 Bemoval from State Baltimore, MD 4 Donation 5 Other (Specify) 2012 21. Signate of Fineral Service Lo 22. Name and Address of Facility Barranco & Sons, P.A. Severna Park Funeral Home Severna Park, MD 21146 495 Ritchie Hwy ter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death ock, or heart failure. List only one cause on each line. mmediate C use (Final disease or ndition resulting in death) aements a Ph_sician/ Medical Due to (or as a consequence of) Examiner quentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): burial-trar that initiated events Due to (or as a consequence of): resulting in death) Last ed by the attending physician detached for use as the buria Be Completed by Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death.

To the Funeral Director, After this certificate has been signed by the attending physicis completely filled in by the funeral director, page 2 should be detached for use as the bu P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Other (specify) Pregnant at time of death 1 ☐ Yes 2 ☐ 9 ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 1 Tes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy death? 2 🗌 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 🗹 No မ 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 1 Natural 28c. Injury at 28d. Describe how injury occurred 5 Pending injury work?
1 Yes 2 No Accident Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical

20 84

> Registrar DHMH 17 Rev 06-2011

State

29a. Certifier

only one) 29b. Signature and title of certifie

Panduse

Pandove

MAR 02 2012

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

veterans

8601

1 💆 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

D0048244

Highway, Millorwille, MD

29d. Date signed (Month, Day, Year)

2-2912

29c. License number

12-01951 Ronald Morese C	live	Please Type or Print in Black Inc. , Jr State of Maryland / Depa	delible in	nk. Ensure All Cop Health and Mental I	ies Are Legi Ivgiene	ble.	
Nonaia Mologo			tificate of		Reg.	No. 2012	2 0852
Physicia	n/	. Decedent's Name (First, Middle,Last)			2. Date of Death Month D March 7, 20	ay Year	3. Time of Death 2341 hrs
Medical Examin		Ronald Morese Oliver, Jr.		b. City, Town, or Location of Dea		4c. County of Death	
		Meritus Medical Center		Hagerstown		Washington	
Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. Ia 800-69-0228 1 X M 2 F	st birthday) Yrs.		in. Aug . 8	MM/DD/YYYY) 9. Birtl Foreign 2 () 1 1 Cou	nplace (State or n _{intr} Maryland
	ŀ	Jsual Residence of Decedent	115.	0 20	Aug. 0	,2011	
Aue A			Town or Location				10d. Inside City Limits 1 X Yes 2 No
Maryland 28a-f show d at once.	호	, , ,	erstown	1	100	. Citizen of What Coun	
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 37 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once	Director	10e. Street end Number 309 East Ridge Dr.		21740		U.S.A.	.,,
with th		11. Marital Status 12. Was Decedent Ever in U.S.	5. 13. Wa	s Decedent of Hispanic Origin? (Specify Yes or No-	14. Race - Americ White, etc.	can Indian, Black,
death	Funeral	1 Never Married 2 Married Armed Forces? 1 Yes 2 No		es, specify Cuban, Mexican, Puer	to Rican, etc.)	Specify: Blac	·ŀ
s after rral",	ক্র	3 Widowed 4 Divorced If Yes, Give Year or Dates: 15. Decedent's Education (Specify only highest grade completed)		Yes $2 \overline{X} $ No specify: t's Usual Occupation (Give kind of	f work done	6b. Kind of Business/Ir	
2 hour	eted	Elementary/Secondary (0-12) College (1-4 or 5+)	during mo	ost of working life. DO NOT use r		/ -	
1036	Completed	0	N/2			N/A	
21215-0036 21215-0036 Juld be filed within 7 Mental Hygiene. marked other than ic event, the Medica	Be Co	17. Father's Name (First, Middle, Last) Ronald Morese Oliver, Sr.			ne (First, Middle, Ma a Michell		
212 ould be Menta mark	P P	19a. Informant's Name/Relationship (Type, Print)	1	Address (Street and Number of	r Rural Route Number	er, City or Town, State,	Zip Code)
MD ad 2 shoulth and m 27 is aumati		Ronald M. Oliver, Srfather		ast Ridge Dr. H		, MD 21740	Town State
of Hear In item	-	4 TO Buriel 2 Committee 2 Pamayal from State	rematory or oth	ition (Name of cemetery, her place)			·
Baltimore, permit. Pages l ar Department of Hee Important: U ite		4 Donation 5 Other Specify: 21. Signature of Funeral Service Licensee		Cemetery 3-		Hagerstown	
Bal permi Depar Impo		Dung Frien	13	331 Eastern Blv	d. North H	Hagerstown,	MD 21742
Physician		23a. Part I. Enter the disease, or complications that caused the death. failure. List only one cause on each line.	Do not enter th	ne mode of dying, such as cardia	or respiratory arres	t, shock, or heart	Approximate Interval Between Onset and
Medical Examiner	- 1	Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of	D				Death
		b).				
	xaminer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause):				
uted d ansit	Ш	(Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of d.):				
e executec cian and rial - trans	gigal	■ MENDED 23a,27,2	8a-f,pe	er me,g928 6-1-	12 sm		
Box 68760, e death certificate be the attending physic ed for use as the bur	8	F FEMALE: 3b. Was decedent pregnant in the	· 🖂 –	tal death 3 Ectopic pres	inancy	23d. Date of delivery Month D	ay Year
x 68 h certi tending	iciar	past 12 months? 4 Pregnant at time of de	-th - =	her (Specify)		k	5
. Bo he deat y the at	Physician/Medical	1 Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not re	esulting in the u	inderlying cause given in Part I.	23e. Did tob	acco use contribute to	he cause of death?
of Vital Records, P.O. Box 68760, ing Physician: The law requires that the death certificate be execute. After this certificate has been signed by the attending physician and funeral director, page 2 should be detached for use as the burial - tran	<u>a</u>				1 Yes	2 ✓ No 3 Prob	ably 4 Unknown
rds v requi	Completed				24a. Was an autopsy	prior to c	topsy findings available ompletion of cause of
RecC The lay cate ha	E				perform 1 ✓ Yes 2		s 2 No
cian:	Be	25. Was case referred to medical examiner? Hospital: 1 Inpatient 2	ER/Outpatient	26.Place of Death (Che		esidence 6 Other	
of Vi	ို	27. Manner of Death 28a. Date of Injury	28b. Time of I		28d. Describe ho		
ion c ttending death. ttor: Af	cation:	Natural 5 Pending (Month, Day, Year) X Accident Investigation fd 3-7-12	fd 10:3			drowned in	
Division of Vital Records, P.O. Box 68760, to the Hospital or Attending Physician: The law requires that the death certificate be vithin 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physici ompletely filled in by the funeral director, page 2 should be detached for use as the buri	Certific	3 Suicide 6 Could not be 28e. Place of Injury - At ho	ome, farm, stree Reside:	et, factory, office building, etc.	28f. Location (Str or Town, Sta Hagersto	te) 309 East I own, MD.	ral Route Number, City Ridge Dr.
Hospit 24 houn Funer	N N	29a. Certifier 1 Certifying Physician: To the best of my knowledge	ne death occur	red at the time, date and place, a	and due to the cause	s) and manner as state	ed.
To the vithin vithin to the comple	edical	(Check only one) 2 Medical Examiner: On the basis of examination a and manner stated.	nd/or investigat	tion, in my opinion, death occurre		and place, and due to the	

State Registrar

29b. Signature and title of certifier

Ana Rubio MD.

30. Name and address of person who completed cause of death (Item 23a)

Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223

29c. License number O.C.M.E.

29d. Date signed (Month, Day, Year)

March 8, 2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 2012^{Year} Physician/ MARCH 3 NICHOLAS THOMAS PAUL 5:37 Рм Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death CAROLINE HOMESTEAD MANOR DENTON 5. Social Security Number 7. Age (In yrs. last birthday If Under 1 Year If Under 24 Hrs. 8. Date of Birth g. Birthplace (State or Foreign **Funeral** NEW YORK Months Days Hours 1 **X** M 2 □ F 10/12/1916 Director 097-10-5197 95 Usual Residence of Decedent ms 23a or 28a-f show must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No TALBOT WYE MILLS 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 13552 RUSTLING OAKS DRIVE 21679 UNITED STATES nould be filed within remained Mental Hygiene.
is marked other than "natural", or items for a marked other than "nearest my seem, the Medical Examiner my items 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14 Race - American Indian, Armed Forces?

1 X Yes 2 \sum No 1942-Black, White, etc. 1 Never Married 2 Married Completed by Maryland 21215-0036 1 ☐ Yes 2X No Specify: 3 Widowed 4 Divorced If Yes, Give Specify: WHITE 1965 Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) CHIEF WARRANT OFFICER UNITED STATES ARMY Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ NICHOLAS STANLEY PAUL STELLA AGNES MOJECKI 1 and 2 should by Health and Meitem 27 is mark 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) CHRISTINE HELFENBEIN / DAUGHTER 13552 RUSTLING OAKS DR., WYE MILLS, MD 21679 injury or other Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of permit. Page 1 a
Department of H
Important: If ite
any injury or ot 20c. Location - City or Town, State cemetery, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) HAMILL CEMETERY 03/07/2012 KITZMILLER, MD 21. Signature of Funeral Service Lice FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME, P.A. 106 SHAMROCK ROAD, CHESTER, MD 21619 entel 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only the cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ arknow disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Hollage) Examine Due to (or as a consequence of) death certificate be executed physician and s the burial-trans Cause (Disease or Illijury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Box 68760 attending p for use as t IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?
1 Yes 2 No Pregnant at time of death 5 Other (specify) Month Dav Year 4 ☐ Pregnant 9 ☐ Unknown signed by the a d be detached f 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 Yes 2 No 3 Probably 4 Unknown peen 24b. Were autopsy findings available prior to completion of cause of 24a Was an cate has page 2 s autopsy performed death? Hospital or Attending Physician: The certificate 2 No 1 Tes Yes 25. Was case referred to medical Division of Vital Be 26. Place of Death (Check only one) examiner? 1 Tyes 2 No Other: ျ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Nother (Specify) funeral 27. Mann of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending work s after death I Director: A d in by the fu 2 Accident
3 Suicide
4 Homicide 1 Tes 2 🗌 No Investigation Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined filled in 24 hours a Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier completed (Check within 2 To the I Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signaty re and title of certifier 29d. Date signed (Month, Day, Year) MI 100053255 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State

Registrar
DHMH 17 Rev 7/2009

3683

59 Anstra

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death ^{Day} 28 Physician/ 10:30 PM Paul 2012 Dale Merrill February Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner Anne Arundel Crownsville Fairfield Nursing & Rehab Center Social Security Number 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** Days (Month, Day, Year) Hours 73 167-30-2274 **Director** 1 X M 2 🗆 F March 13,1938 Pennsylvania Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits Director 3a or 28a-f sh t be notified Anne Arundel Severna Park 1 ☐ Yes 2 🕅 No MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 23a USA 21146 259 Whistling Pine Road items death 12. Was Decedent Ever in U.S.
Armed Forces? 19561 X Yes 2 No 1960 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black White etc. ō Completed by 1 Never Married 2 X Married Page 1 and 2 should be filed within 72 hours after Baltimore, Maryland 21215-0036 White 1 Yes 2 No Specify "natural" 3 Widowed 4 Divorced Year or Dates Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) ed other than " event, the Med Elementary/Secondary (0-12) College (1-4 or 5+) Advertising 12 Sales Manager Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Mental and.

of Health and

filem 27 is mark.

r traumatic ev မ Ethel Gabriel Walter Paul 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code 259 Whistling Pine Road Severna Park, MD 21146 Connie Paul / Wife 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Department of ± 5 1 Burial 2 XCremation 3 Removal from State March 02 Important: If any injury or once, 4 ☐ Donation 5 ☐ Other (Specify) 2012 Baltimore, MD Metro Crematory, INC. 22. Name and Address of Facility Barranco & Sons, P.A. Severna Park Funeral Home 495 Ritchie Hwy, Severna Park, MD 21146 Signature of Funeral Service Licensee 23a. Part 1. Enter the bisease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or feart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) **Medical** Examiner Sequentially list conditions. Examine cause. Enter Underlying Cause (Disease or injury for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) nding physician Physician/Medical P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Day Pregnant at time of death 5 Other (specify) detached 9 Unknown ned by 1 Part II, Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by s been signer should be c 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available 24a. Was an prior to completion of cause of death?

1 Yes 2 No autopsy page 2 director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 1 Yes 2 No မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) this funeral 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work?
1 Yes 2 No Certificate: 28d. Describe how injury occurred After 5 Pending injury 1 X Natural Accident Investigation the Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, ☐ Homicide determined

Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, s after death filled in by 24 hours completely within 2 To the F the

Medical 29a. Certifier 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

3 Certifying Murse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature ar 29c. License number 29d. Date signed (Month, Day, Year) who completed cause of death (Item 23a) (Type, Print) Name and address of perso State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death THELMA Physician/ HAWKINS **POPHAM** gay q MARCH 2012 12:10P M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death LAUREL REGIONAL HOSPITAL LAUREL PRINCE GEORGE'S Social Security Number 6. Sex 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 8 Date of Birth Birthplace (State or Foreign Country) **Funeral** 1 M 2 TF Days Months Hours Min (Month, Day, 258-24-1120 Director 88 STR 26,1924 GEORGIA Usual Residence of Decedent ir than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10a, State 10c. City, Town or Location 10d. Inside City Limits Director MD CHARLES NEWBURG 1 Yes 2 No 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 15804 LANCASTER FARM ROAD 20664 U. S. A. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 Yes 2 No þ 1 Never Married 2 Married Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 🔀 No Specify: 3 Widowed 4 Divorced Specify: WHITE Completed 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) 12 PERSONNEL MANAGER STATE DEPARTMENT Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) should be file and Mental F is marked of THOMAS SHERMAN HAWKINS LILLIE MAE IVENS 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) PEGGY DEMING / NIECE Health a tem 27 i 15804 LANCASTER FARM RD., NEWBURG, MD 20664 per nit. Page 1 and 2 Department of Health Important: If item 27 any injury or other t Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State METRO. CREMATORY 4 ☐ Donation 5 ☐ Other (Specify) 03/12/2012ALEXANDRIA, VA 22. Name and Address of Facility RAY MOND FUNL. SERVICE, P.A. Signature of Funeral Service Ligenses 00641 5635 WASHINGTON AVE., LA PLATA, MD 20646 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ SEPTICEMIA disease or condition 2-4 WEEKS Medical resulting in death) Due to (or as a consequence of): Examiner PNEUMONIA Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury 2-4 WEEKS Examine Due to (or as a consequence of) that initiated events Due to (or as a consequence of) resulting in death) Last physician a the burial-t Medical 68760 as IF FEMALE: ase 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death Physician/ 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months? Pregnant at time of death 5 Other (specify) Month Day Year 1 Yes 2 No 9 Unknown þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by sign Records, END STAGE RENAL DISEASE 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown ATRIAL FIBRILLATION 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an page 2 autopsy performed? 1 ☐ Yes 2 ☐ No Physician: 25. Was case referred to medical funeral director, Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2**X**N0 ၉ 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: al or Attending P s after death. Il Director: After t d in by the funera 28c. Injury at 28d, Describe how injury occurred 5 Pending Natural injury work? 1 Yes 2 No Accident
Suicide Investigation 6 Could not be within 24 hours after de:

To the Funeral Directo

completed filled in by th 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Hospital Medical 1 Sertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only one 29b. Signature and title of certifier

State

Box (

o.

of Vital

Division

DHMH 17 Rev 7/2009

Registrar

1-175650146

MICHAEL BAAKO, M.D., 3450 FT. MEADE RD. #209 LAUREL,

BHY OCIM

32. Registra s Signa

was Jue

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29c. License number

DE057216

MARCH 9,

MD 20724

2012

			ase Type or Pr State of M				k. Ensure A	-	_	e.
		For State Registrar		, , , , , , , , , , , , , , , , , , ,		ificate of L			Reg. No. 2	2 1852
Physicia	ın/	Decedent's Name (First, Middle KATHLEEN	JOYCE	PUZ	ZILLA	A		2. Date of Dea Month	Day Yea	
Medic Examin		4a. Facility Name (if not institution ST • THOMAS N				4b. City, Town, or	Location of Death	MARCH	4c. County of D	20
Funeral Director		5. Social Security Number 456-80-5977	6. Sex 1 ☐ M 2 🔀 F	ge (In yrs. last t		If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birt (Month, Day JUNE	v. Year)	Birthplace (State or Foreign Country) PEXAS
faryland Ba-f show tified at	Director	Usual Residence of Decedent 10a. State 10b. County MD CHARI	LES	10c. City, To	own or Loca					10d. Inside City Limits 1 ☐ Yes 2X No
th the A		10e. Street and Number	ICE DOTVE	1		10f. Zip Code	16		10g. Citizen of What	
eath wi	Funeral	9160 PREFEREN	12. Was Decedent				ispanic Origin? (Spe		U . S	merican Indian,
2 hours after death with the Maryland "natural", or items 23a or 28a-f show ede at Examiner must be notified at	þ	1 ☐ Never Married 2 🔀 Mar 3 ☐ Widowed 4 ☐ Divorced	If Voc Give			Yes, specify Cuba	ın, Mexican, Puerto Specify:	Rican, etc.)	Black, W Specify:	hite, etc.
	Completed		nt's Education est grade completed) College (1-4 or	5+)	(Give ki. life. DO	NOT use retired)	ation during most of work STATIS!		16b. Kind of Busine CENSUS	
e 1 and 2 should be filed within 7 of Health and Mental Hygiene. If item 27 Is marked other than If item 27 Is marked other than in other traumatic event, the M	To Be	17. Father's Name (First, Middle, to JAMES ABLE	,	. I			18. Mother's Nam	e (First, Middle,	Maiden Surname) TORIAN J(OHNSON
2 should th and N 7 is ma		19a. Informant's Name/Relations			-				r, City or Town, State,	
1 and 2 of Healt fitem 2		20a. Method of Disposition		20b. Place	e of Dispos	ition (Name of atory or other place	MADA	100.00	20c. Location - City	
permit. Page 1 a Department of H Important: If ite any injury or ot once.		1 Burial 2 🛣 Cremation 4 Donation 5 Other (\$	Specify)		RO.CF	REMATOR	Ý 13,	2012	ALEXANDI	
Depa Impo any i		21. Signature of Funeral Service L	A State	M0064						RVICE, P.A. ,MD 20646
Physician/ Medical		23a. Part 1. Enter the disease, or shock, or heart failure. List of Immediate Cause (Final disease or condition resulting in death)	only one cause on each line.	ne. UOSCL	Encit		g, such as cardiac			Approximate Interval Between Onset and Death
Examiner			Due to (or as	s a consequent	ce of):					
ed nsit	xaminer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury	Due to (or as	s a consequenc	ce of):					
be executed sician and burial-transit	1-20	that initiated events resulting in death) Last	C. Due to (or as	s a consequenc	ce of):					
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funcal Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transi	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcom 1	2 Fetal de at time of deat	eath 3 🗌	Ectopic pregnand Other (specify)	су		23d. Date of Month	delivery Day Year
ss that the igned by be detailed	by P	Part II. Other significant condition			-	derlying cause give		1		to the cause of death?
v require been s should	Completed by	1ty per tensis	n / Diaba	etes in	-117.	tys/N	evictal.	h 4 24a. Was	an 24b. Were	autopsy findings available
The lav cate has page 2		1175/vry of 1	ERICARDIA	LEFF	25101	V		autop perfo 1 \(\sum \) Yes	ormed? death	to completion of cause of ? Yes 2 \sumbox No
yslcian: is certific director,	To Be	25. Was case referred to medical examiner? 1 Yes 2 No	Hospital:	utient 2 □ ER	/Outpatient	_ Oth	er:		dence 6 Other (Sp	pecify)
ding Ph h. After thi funeral		27. Manner of Death 1 Natural 5 Pendi			b. Time of injury	28c. Injur work M 1 🗆	y at		now injury occurred	
al or Atten s after deat I Director: d in by the	Certificate:	2 Accident Investi 3 Suicide 6 Could 4 Homicide determ	not be 28e. Place of Ir	njury - At home etc. (Specify)	e, farm, stree	et, factory, office	100 2 2 110	28f. Location (S City or Tow	Street and Number or vn, State)	Rural Route Number,
Hospitt 24 hours Funera leted fille	Medical	(Check 2 Medical I	Physician: To the best of Examiner: On the basis of Nurse Practioner: To the	examination an	nd/or investig	gation, in my opinio	on, death occurred a	t the time, date a	and place, and due to t	ne cause(s) and manner stated
To the	2	29b. Signature and title of certifie	r		7	29c. Licens	e number		29d. Date signed (Mo	onth, Day, Year)
C CM		30. Name and address of person	who completed cause of	death (Item 23	la) (Type, Pr	int)	10 3 4		MARKCH	140 20181
7		Paul A. V.	JE VORE	MA 42 trar's Signatur	03 6	QUEONS	ibuny 2	d 1-199	ittsville	140 20781
Stat Registra		31. Date filed (Month, Day, Year) NAR 1 9 2012	2 Several	A. A.	arked					

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ 8:30 A.M 2012 February 4a. Facility Name (if not institution, give street and number, Medical 4c. County of Death 4b. City, Town, or Location of Death Examiner Anne Arundel Annapolis LaCasa, Inc. 9. Birthplace (State or Foreign Social Security Number last birthday) if Under 1 Year If Under 24 Hrs. 8. Date of Birth **Funeral** Months Days 1 □ M 2 💢 F 0573071927 Washington, 84 Director 578-30-4255 Usual Residence of Decedent 10d. Inside City Limits or 28a-f shov 10c. City, Town or Location permit, Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f shon any injury or other traumatic event, the Medical Examiner must be notified at 10a. State Director 1 ☐ Yes 2 🕅 No MD Calvert Huntingtown 10f. Zip Code 10g. Citizen of What Country? 10e Street and Number Funeral Cari 5851 Road 20639 U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces?

1 Yes 2 X No Black, White, etc. 1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify. Yes. Give Specify 3 X Widowed 4 □ Divorced white Year or Dates 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+ own home homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Carroll Mack Soo Margaret Ν. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Deborah Lee Martini, daughter 5161 South Creek View Way, Churchton, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State 4 🗋 Donation 5 🗆 Other (Specify) MD Veterans Cemetery 03/01/2012 Cheltenham, MD 21. Signatur Funeral Service License 22. Name and Address of Facility Rausch Funeral Home, P.A. 8325 Mt. Harmony Lane, Owings, MD ase, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, s. List only one cause on each line. Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications shock, or heart ailure. List only one cause Immediate Cause (Final Physician disease or condition resulting in death) Medical Due to (or as a consequence of Examiner Sequentially list conditions Examiner if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of). To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director. After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Day Month Year Other (specify) Pregnant at time of death 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Be 1 🗌 Yes 2 NO ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Certificate: To 1 Inpatient 2 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 1 □ Yes 2 □ No 28d. Describe how injury occurred 1 Natural 5 Pending Accident Investigation 3 ☐ Suicide 4 ☐ Homicide Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical crtifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 29b. Signature and 29c. License number 29d. Date signed (Month, Dav. Year)

State

31. Date filed (Month, Day,

s Signature

THICUM

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MAR

32. Registra

		For State	State of Ma	ryland /					ntal Hy	giene	201	2 1052
		Registrar	4)		Cei	tificate of I	Death			Reg. No.	201	C Time of Dooth
Physicia	ın	1. Decedent's Name (First, Middle, Las		ZVK	Ke	~		2	Date of De Month	Day	Year	3. Time of Death
/Medic		4a. Facility Name (If not institution, give		3/	, ,	4b, City, Town, or	r Location	of Death	20	≥ (c 4c,	고 6/고 County of Dea	1 2
Examine	er	432 Girard	STI	203		Gath	ersb	oxa		n	1001	to ones 4
Funeral		Social Security Number 6. Security Number	7. Age	(In yrs. last t		If Under 1 Year Months Days	If Under Hours	l Min	Date of Bir (Month, Da	av. Year)	C	hplace (State or Foreign
Director		220-40-6944	L M 221F	71	Yrs.			I	eb. 2	9,19	40 Mi	Innesota
land ow	ŀ	Usual Residence of Decedent 10a. State 10b. County		10c. City, To	wn or Lo	cation						10d. Inside City Limits
Mary Ind	ţo	Maryland Montgom	erv	Ga	ithe	rsburg						1 X Yes 2 No
h the	(A)	10e. Street and Number				10f. Zip Code				10g. Citiz	zen of What Co	ountry?
be filed within 72 hours after death with the Maryland htal Hygiene. ad other than "natural", or items 23a or 28a-f show event, the Medical Evaminar must be notified at	ral	432 Girard Street	, #203				20877				USA	
er des	Funeral	11. Marital Status	12. Was Decedent E Armed Forces?		13. \	Was Decedent of H f Yes, specify Cuba	lispanic Oi an, Mexica	rigin? (Speci an, Puerto Ric	fy Yes or No can, etc.))-	 Race - Ame Black, White 	erican Indian, e, etc.
rs affe	by F	1 ☑ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 ∐Yes 2 X No If Yes, Give Year or Dates:	0		1 □Yes 2X No	Specify	<i>'</i> :			Specify: V	Vhite
2 hou	ted	15. Decedent's Ed	ucation	16	a. Dece	dent's Usual Occup	ation			16b. Kir	nd of Business	/Industry
hin 7. e. an "n	Completed	(Specify only highest grave) Elementary/Secondary (0-12)	de completed) College (1-4or 5+	-)		kind of work done OO NOT use retired					_	
ygien ygien ser th	Con			Cı	usto	mer Servi	-					rance
be file	Be	17. Father's Name (First, Middle, Last)	•					ner's Name (f			•	t
hould d Mer marke	ဋ	Kermit Burton Ryk 19a. Informant's Name/Relationship (1,1	Ob Mailir	ng Address (Street					e Bohr:	
id 2 sl Ith an 27 ls i		Rolf T. Rykken/Br				17th Str				•		
s 1 an f Hea item 3	15 1	20a. Method of Disposition		20b. Place	of Dispo	sition (Name of matory or other place	1	Dat			cation - City or	
permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examinar must be notified at once.		1 ☐ Burial 2 【XCremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specification 5 ☐ Other (Specification Specification Specifi				tan Crem	· i	02/28/	2012	A1e3	kandria	. VA
permit. Departin Importa any inju		21. Signature of Funeral Service Licen		1110010		2. Name and Addre		lia.			1 Home	.,
8 3 E 8 8		Papan M=7	Millian	MO120	2 10	E. Deer	Park					
		23a. Part 1. Enter the disease, or comp shock, or heart failure. List only	olications that caused one cause on each ling	the death. D e.	o not ent	er the mode of dyir	ng, such a	s cardiac or i	espiratory a	arrest,		Approximate Interval Between Onset and Death
Physician		Immediate Cause (Final disease or condition resulting in death)	a	150	·V	0						DMG
/Medical Examiner		resulting in death)	Due to (or as a	consequenc	e of):							
	ē	Sequentially list conditions,	b Due to (or as a	consequenc	e of):							
uted	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	,									
an an	Exa	resulting in death) Last	Due to (or as a	consequenc	e of):							
cate be executed physician and the burial transit	dical		d									
ertific ling p	Med	IF FEMALE:									-	
attend for us	by Physician/Me	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of 1 Live birth 2 4 Pregnant at	2 🗆 Fetal dea		☐ Ectopic pregnand ☐ Other (specify) _	су			2	23d. Date of de Month	elivery Day Year
the de	ıysic	1 □ Yes 2 ⊠No 9 □ Unknown	9 Unknown	time of death	1 3	_ Other (specify) _						
that hed by detail	y Ph	Part II. Other significant conditions	ontributing to death bu	t not resulting	g in the u	nderlying cause giv	en in Part	1.	23e. Did	tobacco u	se contribute	to the cause of death?
quires en sig									1 🗆	Yes 2	No 3□ F	Probably 4 🗌 Unknown
aw rei	Completed								24a. Was			utopsy findings available completion of cause of
The I	mo;								perfe	ormed?	death?	s 2 No
cian: ertific	Be	25. Was case referred to medical examiner?						ce of Death (
hysic this cal	၉	1 XYes 2 □ No	Hospital: 1 ☐ Inpatie			IL OLI DON			- 4		6 □Other (Sp	ecify)
ding F	Certification:	27. Manner of Death 1 Natural 5 □ Pending	28a. Date of Injur (Month, Day		o. Time o injury	Wor	ryat rk?]Yes 2.[d. Describe	how injur	y occurred	
death ctor: y the	ficat	2 Accident investigation 3 Suicide 6 Could not be		rv - At home.	farm, str		1165 2		f. Location	(Street an	d Number or F	Rural Route Number,
after after Dire	ertii	4 Homicide determined	28e. Place of Inju building, etc	(Specify)	,	,			City or To	wn, State)	,
To the Hospital or Attending Physician: The law requires that the death certific within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending prompletely filled in by the funeral director, page 2 should be detached for use as	Medical C		ysician: To the best on niner: On the basis of and manner sta	examination								
o the	Med	29b. Signature and title of certifier	/)			29c. Licens	se number	-		29d. Da	te signed (Mor	nth, Day, Year)
		Mass S.	secher	DO		, ,,,	,			So	-	2012
		30. Name and address of person who IKR N B	completed cause of de	eath (Item 23:	a) (Type,	DME	511	ifa ver i	or CB	709	mo	40904
Stat		31. Date filed (Month, Day, Year)	32. Registra	r's Signature	book	J.			J	0		>
Registra	ar	MAR U 2 2012	andre	p. 19	1400							,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

2			2	0	8	5	3	-
See	W	2	Acres	-	100	\sim	V	- 5

		1- For State Registrar	Certificate of Death						Reg. No.	. 0 1 2	
Physici	an/	1. Decedent's Name (First, Middle						2. Date of De Month		rear :	3. Time of Death
Medical Exami	ner		MICHAEL F	REAM				March 9	, 2012		1535 hrs
		4a. Facility Name (if not institution			4	b. City, Town, or I		ath		ty of Death	
		9704 Beaver Dam Roa	id # 319			Lutherville T				ore Cour	
Funeral		5. Social Security Number	6, Sex 7. Age	e (In yrs. last bir	thday)	If Under 1 Year		20.	Birth (MM/DD/YY	Foreign	
Director	Н	166-66-1598	1X M 2 F	27	Yrs.	Months Days	Hours I	^{viin.} 06/	20/1984	Cour	PENNSYLVANIA
	l	Usual Residence of Decedent									
y any		10a. State 10b. County		10c. City, Town	or Locatio	n					10d, Inside City Limits
and show	5	MARYLAND C	ECIL			NORTH	EAST				1 X Yes 2 No
4aryl 28a-1	Director	10e. Street and Number				10f. Zip Code			10g. Citizen of		
hours after death with the Maryland 'natural', nr items 23a nr 28a-f sho Examiner must be notified at once.		34 SALVATION	CIRCLE			2190	1		UNI'	TED SI	PATES
with ps 23	Funeral	11. Marital Status	12. Was Decedent	Ever in U.S.		Decedent of His				ace - America	an Indian, Black,
death ir ite	Ě	1 X Never Married 2 Ma	rried Armed Forces?	X No	II TE	s, specily Cuball,	, IVIEXICAN, FUE	ato Rican, etc.)	""		
	ā		rced If Yes, Give Yeer or Dates:		1 🗌	Yes 2 X No	specify:		Specif		
nours Exam		15, Decedent's Education (Speci				s Usual Occupati st of working life.			16b. Kind of	Business/In-	dustry
2 , 3	Completed	Elementary/Secondary (0-12)	College (1-4 or 5	i+)	DUZ	· · · · · · · · · · · · · · · · · · ·			DITT	л рмасч	7
5-003(fled within Hygiene. d other tha	Ē	47 Fatt of Name (First North)		13	Pn	ARMACIST		ann /Finnk Béidelle	, Maiden Surnar	ARMACY	
filed Hyg		17. Father's Name (First, Middle, I				- 1		, ,		ne)	
21215-0036 nuld be filed within 7 Mental Hygiene. marked other than ic event, the Medica	9 Be	JAMES MICHAEL 19a. Informant's Name/Relationsh		10	h Mailing	Address (Street		SETH FOR		own State	Zin Code)
MD 2 d 2 shou lith and h	우	ELIZABETH REAM		- 4		ARPENTER:					
rre, MD 2's 1 and 2 should freath and M If item 27 is mer traumatic	ŀ	20a. Method of Disposition	/ POTILIN			ion (Name of cen		Date	20c. Locatio		
= 0 7 F F F		1 Burial 2 X Cremation	3 Removal from Sta	10	tory or othe		.,) / 4 ET / 4 O	CT Th	DUDAIT	T 10
timent trant	I	4 Donation 5 Other Spe		ATLAN		REMATOR		3/15/12	GLIEIN	BURNI	E, MD
Baltimore, permit. Pages 1 ar Department of Hee Important: If ite injury or other tr		21. Signature of Funeral Service L	icensee		22. Na	me and Address	TT FUNI	ERAL HOM	E, P.A.		
		23a. Part I. Enter the disease, or o	complications that caused	the death Do no	nt enter the	552 LEWI	S STREE	CT HAVR	E DE GRA	ACE, M	1D 21078 Approximate Interval
Physician Wedical		failure. List only one cause of	on each line. Combin	ed drug	(hydr	oxyzine,	,cnlord	liazepox	ide, and	louit	Between Onset and Death
£xaminer		Immediate Cause (Final disease or condition resulting in death)	a. Phenobarbi		icit	y complic	cated b	y cardio	megaly		Deatti
		WHICH THE PROPERTY OF THE PROP	b Due to (or as a conse	quence or).						()	
	9	Sequentially list conditions, if any, leading to immediate	Due to (or as a conse	equence of):							
	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated	с								
ed sit	X	events resulting in death) Last	Due to (or as a conse	quence of):						-	
executed an and al - transit		X UNPENDED	d. X AMENDED 23a	nt.II.	27.28	a-f.ner	me.e92	6 4-25-	12 sm		
760, cate be ex physician the burial	/Medical		27 1	er me	926,	<u>04/27/20</u>	12dhb		12010		-
- NO	١	IF FEMALE: 23b, Was decedent pregnant in the	23c. If yes, outcom			aldeath 3	Ectopic pre	onancy	Month	of delivery Da	ay Year
Box 68's death certiff he attending defor use as	cia	past 12 months?				er (Specify)					
Boy e death the att	Physician	1 Yes 2 No 9 Unkr	own 9 Unknown								
that the ned by the detache		Part II. Other significant condition	ons contributing to death	but not resultin	g in the ur	derlying cause g	iven in Part I.				ne cause of death?
P.O. res that the signed by be detact	a b	Asthma, Steat	osis of the	liver				_ I I U Y	'es 2 ✔ No	3 Proba	bly 4 Unknown
ords, w requir is been s	Completed by							24a. Wa	is an 24b		ppsy findings available mpletion of cause of
e law e has ge 2 s	티	1.00						per	formed?	death? 1 ✓ Yes	
tal Rection: The certificate ector, page		25. Was case referred to medical	T			26 Place	of Death (Che		2 110	1 7 103	2 110
Vital Rec	a	examiner?	Hospital: 1 Inpatie	nt 2 ER/O	utpatient		Aut	rsing Home 5	Residence 6	Other:	Scene
of Vital Records, ing Physician: The law require After this certificate has been si uneral director, page 2 should b	6	1 Yes 2 No 27. Manner of Death	28a, Date of Inju (Month, Day,Y		Time of In	jury 28c. Injur	y at Work?	28d. Describ	e how injury occi	urred	
ion of Vital Records, P.O. Box 68 tending Physician: The law requires that the death certifeath. tor: After this certificate has been signed by the attending the funeral director, page 2 should be detached for use as	틸	1 Natural 5 Pendi			2.20	1 Y	es 2 χ No	subjec	t inget	sed di	rugs
Division tal or Attendi rs after death.	<u>i</u> g		igation fd 3-9- 28e. Place of In		3:29 arm, street	, factory, office bi	uilding, etc.	28f. Location	(Street and Nun	mber or Rura	al Route Number, City
Divis ospital or / hours after ineral Dire y filled in t	Certification:	3 X Suicide 6 Could 4 Homicide determ	not be (Specify)	Resider	ice			or Town	, State) 9704 Lutherv	Beave	er Dam Rd.
Divis To the Hospital or At within 24 hours after d To the Funeral Direct completely filled in by		20- 0-45	ysician: To the best of m			ed at the time, da	te and place.				
To the J within 2 To the J complet	Medical		niner:On the basis of exar								
F 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	Z E	29b. Signature and title of certifier	and manner stated.			29c. License	e number		29d. Date si	gned (Mont	h, Day, Year)
		n 4 /1-				O.C.N	И.E.		March 10), 2012	
	ŀ	30. Name and address of person v	who completed cause of d	eath (Item 23a)							
		Donna M. Vincenti, MD			900 \	W. Baltimore	Street, Ba	Itimore, MD 2	21223		
S	tate	31. Date filed (Month, Day, Year)	32. Registra	's Signature	1	, ,					
Regis		MAR 14	2012	m B.	, Ga	ekel					

12-01919

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

aria Patricia S		1- For State Cen	tificate of Death	Reg. No.	2 0853
Physici	_	Registrar 1. Decedent's Name (First, Middle,Lest)		2. Date of Death	3. Time of Death
ledical Exam		Carla Patricia Sipe	4b. City, Town, or Location of De	March 7, 2012	0852 hrs
)		Facility Name (if not institution, give street and number) 983 Margarita Street	Lothian	Anne Arund	
Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. la		Ira	Birthplace (State or reign
Director		215-94-6295 1_m 2\big 38	Yrs. Months Days Hours !	vlin. 12/19/1973 For	CountryMaryland
any		Usual Residence of Decedent 10a. State 10b. County 10c. City,	Town or Location		10d. Inside City Limits
	_	MD Anne Arundel	Lothian		1 Yes 2 No
Aaryland 28a-f show 1 at once.	Director	10e. Street and Number	10f. Zip Code	10g. Citizen of What C	
death with the Maryland or items 23a or 28a-f sho must be notified at once.		983 Margarita Street	20711	U.S.	A .
eath wi items	Funeral	11. Marital Status 1 Never Married 2 Married Armed Forces? 1 Yes 2 X No	S. 13. Was Decedent of Hispanic Origin? If Yes, specify Cuban, Mexican, Pue		
	by Ft	3 X Widowed 4 Divorced If Yes, Give Year	1 Yes 2 No specify:		white
hours a	pe	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+)	16a. Decedent's Usual Occupation (Give kind during most of working life. DO NOT use		ss/Industry
hin 72 e. than "	Completed	Elementary/Secondary (0-12) College (1-4 or 5+)	homemaker	own ho	ome
5-00 led wit Hygien other		17. Father's Name (First, Middle, Last)		ame (First, Middle, Maiden Surname)	Cl. : .
121 Id be fi fental J	o Be	Benjamin Andrew Ort 19a. Informant's Name/Relationship (Type, Print)	Carla 19b. Mailing Address (Street and Number		Chite
by MD 21215-0036 and 2 should be filed within 72 hours after death with the Maryland fealth and Mental Hygierd et et er 27 is marked other than "natural", or items 23a or 28s-fabe transmite event, the Medical Examiner must be notified at once	ဥ	Marianne Stiles, sister	1073 Rodgers Road, (Churchton, MD 2073	33
re, P 1 and f Healt ff item er trau			Place of Disposition (Name of cemetery, rematory or other place)	Date 20c. Location - City	or Town, State
Baltimore, permit. Pages 1 as Department of He Important: If ite		4 Donation 5 Other Specify:	- ACHIOL LOL COLLINS	3/12/2012 Dunkirk,	
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after Department of Health and Mental Hygiens Important: If item 27 it marked other than "natural", injury or other traumatic event, the Medical Examiner.		21. Signature of Funeral Service Licensee		Rausch Funeral Home Lane, Owings, MD	e, P.A. 20736
Physician		23a. Part T. Enter the disease, or complications that caused the death. failure. List only one cause on each line. Mixed Dru	Do not enter the mode of dying, such as cardia	ac or respiratory arrest, shock, or heart	Approximate Interval
/Medical		Immediate Cause (Final disease a. Phencycli		nydramine, Fluxeti	ne, Death
		or condition resulting in death) Due to (or as a consequence of):		
	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause):		
	Examiner	(Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):		
50, te be executed hysician and burial - transit	al E	d			-
O, e be ex ysician burial	Aedical	IF FEMALE: 23a, 27 IF FEMALE: 23c. If yes, outcome of pregr	,28a-f per me g925 3-	28-12 vt 23d. Date of deli	verv
Box 68760, e death certificate be the attending physic of for use as the bur	an/N	23b. Was decedent pregnant in the	2 Fetal death 3 Ectopic pre		Day Year
leath ce e attend for use	Physician/N	1 Yes 2 No 9 V Unknown 9 Unknown	other (Specify)		
. 4 . 4		Part II. Other significant conditions contributing to death but not re	esulting in the underlying cause given in Part I.	23e. Did tobacco use contribute	
S, P.O uires that the signed by detac	ed by			NAME OF THE PARTY	Probably 4 Unknown autopsy findings available
cords, P. law requires the has been signed 2 should be designed.	Completed			autopsy prior performed? death	to completion of cause of
tal Rec	5		26.Place of Death (Che	1 Yes 2 No 1 V	Yes 2 No
/ital	Be	25. Was case referred to medical examiner? 1 ✓ Yes 2 No Hospital: 1 Inpatient 2		ursing Home 5 Residence 6 🗸 0	ther: Scene
Division of Vital Records, tat or Attending Physician: The law requir as after death. al Director. After this certificate has been seled in by the funeral director, page 2 should led in by the funeral director, page 2 should	년 :	27. Manner of Death 28a. Date of Injury (Month, Day, Year)	28b. Time of Injury 28c. Injury at Work?	28d. Describe how injury occurred	
ision Attendi	catio	1 Natural 5 Pending Pending Pending Pending Investigation	fd 8:30am 1 Yes 2 X No	unknown 28f. Location (Street and Number or	Rural Route Number City
Divisions after acres after filled in bire	Certification:	3 Suicide 6 X Could not be determined (Specify) Tesic		or Town, State) 983 Mar Lothian, Md.	
Ho Full tely		29a. Certifier Certifying Physician: To the best of my knowled	ne death occurred at the time, date and place,	and due to the cause(s) and manner as	stated.
To the Hos within 24 h To the Fur completely	Medical	(Check only one) 2 Medical Examiner: On the basis of examination at and manner stated.	nd/or investigation, in my opinion, death occurr 29c. License number	29d. Date signed (
	2	29b Signature and title of certifier	O.C.M.E.	March 8, 2012	
		30. Name and address of person who completed cause of death (Item	23a)		
LRW 1		Melissa Brassell, MD Assistant Medical Examir	ner 900 W. Baltimore Street, Balti	more, MD 21223	
S Regis	tate strar	Mar (5) 1	B. Sale		
		/			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Feb. 28, Day 012 Salyer 7:12 Marjorie Saunders Рм 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Hebrew Home of Greater Washington Rockville Montgamery If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 8. Date of Birth Feb. 5, Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 6. Sex Months Hours Days Min Year 927 1 □ M 2 🖳 F 195-20-9504 85 PA Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 1√2Yes 2□No Montgomery Silver Spring 10f. Zip Code 10g. Citizen of What Country? 15115 Interlachen Dr., 20906 Apt. 101 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ∐Yes 2 2 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married White 1 □Yes 2 No Specify. 3 Midowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Manager Banking 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Marjorie Miller Alfred Perry Salver 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mark Ρ. Saunders/Son 14238 Long Green Drive, Silver Spring, MD 20906 20b. Place of Disposition (Name of cemetery, crematory or other place)
Atlantic Crematory 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 2012 Glen Burnie, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Cole Funeral Services, P.A. M00810 4110 Aspen Hill Road, Suite 100, Rockville, MD 20853 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of) IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 🗆 Ectopic pregnancy in the past 12 months? Month Year 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 N/0 3 Probably 4 Unknown 1 🗌 Yes Were autopsy findings available prior to completion of cause of death? autopsy performe 1 □ Yes 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one Hospital: Other: 1∐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation 1 ☐ Yes 2 No 2 Accident 6 Could not be 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)

Physician /Medical Examiner P.O. Box 68760. P. 30 R Vital of Division

law requires that the death certificate be execute

Physician/Medical Examiner attending physician for use as cate has been signed by page 2 should be detach Completed by certificate has Hospital or Attending Physician: funeral director, After this To the Hospital or Attend within 24 hours after death To the Funeral Director: filled in by the соmpletely

Be

Medical Certification: To

4 ☐ Homicide

(Check only one)

29b. Signature and title of certified

29a. Certifier

determined

Physician

/Medical

Examiner

Director

Completed by Funeral

Be

MD

Funeral

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, if a Modical Examinating the matter ance.

Baltimore, Maryland 21215-0036

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 9 11-1)-6121 31. Date filed (Month, Day, Year) Registrar's Signature State Registrar

and manner stated.

1) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death Physician/ February Julia Maria Samuel 1452 2012 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Medstar Montgomery Medical Center Olney Montgomery If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth Birthplace (State or Foreign Country) Months Days Hours Min 214-75-9113 1 M 2 X F 6 01/27/2006 Maryland Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location Director 1 Yes 2 No Maryland Silver Spring Montgomery 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20905 U.S.A. 14829 Silverstone Drive 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Armed Forces?

1 Yes 2 X No Black, White, etc. by 1 X Never Married 2 Married If Yes, Give Year or Dates 1 Yes 2 No Specify: Specify: Indian-American 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) None None Be 17. Father's Name (First, Middle, Last, 18. Mother's Name (First, Middle, Maiden Surname) 2 Sunil Samuel Sibi Thomas 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sunil Samuel - Father 14829 Silverstone Drive, Silver Spring, MD 20905 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) George Washington Cem 03/01/2012 Adelphi, Maryland 22. Name and Address of Facility Hines-Rinaldi Funeral Home, Inc. 1800 New Hampshire Ave., Silver Spring, MD 20904 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Cardiac Arrest disease or condition resulting in death) Due to (or as a consequence of) Respiratory Failure 9 squestially liet or ultione if any, leading to immediate Examiner Physician/Medical \$ Completed

Ph_sician/ Medical Examiner

permit. Page 1 and 2 should be filled wit Department of Health and Mental Hygie Important: If item 27 is marked other 1 any injury or other traumatic event the

Funeral

Director

or 28a-f show notified at

ö

death

Baltimore, Maryland 21215-0036

ritems 23a or ner must be n

er than "natural", or ite the Medical Examiner

ending physician and ruse as the burial transit signed by t d be detach has le 2 page, To the Funeral Briector. After this certificate I To the Funeral Director. After this certificate I at the Funeral director, pag

Be ဂ္

Certificate:

Medical

requires that the death certificate be

Hospital or Attending Physician:

Division of Vital Records, P.O. Box 68760

cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c. Hypoxia Due to (or as a consequence of): Plural Effusion		
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 X No 9 Unknown	23c. If yes, outcome of pregnancy 1		23d. Date of delivery Month Day Year
Part II. Other significant conditions Leukemia	contributing to death but not resulting in the underlying cause given in Part I.		use contribute to the cause of death?
		24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No
25. Was case referred to medical	26. Place of Death (Check or	nly one)	
examiner? 1 Yes 2 X No	Hospital: 1 XInpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home	5 Residence	6 ☐ Other (Specify)
27. Manner of Death 1 🕅 Natural 5 🗆 Pending	(Month, Day, Year) injury work?	d. Describe how inju	iry occurred

🛛 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

D004770

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29d. Date signed (Month. Dav. Year)

February 27, 2012

Registrar

2 Accident

4 Homicide

29a. Certifier

Suicide

29b. Signature and title of certifie

Gebrehiwot Gebru.

Investigation

determined

em

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

6 Could not be

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Deatl Physician/ February 28, 2012 7:50p м Michael Paul Selmer Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Montgomery Silver Spring Holy Cross Hospital 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Hours Director 509-32-8343 78 1X M 2 D F June 10, 1933 OR Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits the Maryland Director ems 23a or 28a-f sh r must be notified a Silver Spring 1 🗌 Yes 2 🔀 No Maryland Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? death with 20906 USA 3210 Norbeck Road #127 ral", or items ? 12. Was Decedent Ever in U.S.

Armed Forces? Korean

1 ☑ Yes 2 ☐ No
If Yes, Give War Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc þ 1 Never Married 2 Married Page 1 and 2 should be filed within 72 hours after Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛣 No Specify: Specify: White "natural" Completed 3 Widowed 4 Divorced Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) other than Elementary/Secondary (0-12) College (1-4 or 5+) nt of Health and Mental Hygiene. If item 27 is marked other that or other traumatic event, the N Self Employed Craftsman Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Mildred A. Stevenson မ Hollis Heath Selmer 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3210 Norbeck Rd., #127, Silver Spring, MD 20906 Onda Krick Selmer / Wife 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 Burial 2 🔀 Cremation 3 D Removal from State cemetery, crematory or other place) March 2, 2012 Department of Important; If any injury or Alexandria, Virginia Metropolitan Crematory 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility. Francis J. Collins Funeral Home, 500 University Blvd., W., Silver 21. Signature of Funeral Service License Inc. Spring, MD 20901 ME 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Ph_{sician/} Cardiopulmonary Arrest disease or condition Medical resulting in death) Due to (or as a consequence of Examiner Respiratory Failure Sequentially list conditions, it my looking him claim cause. Enter Underlying Cause (Disease or injury that initiated events Examine Due to or as a consequence of transit the Hospital or Attending Physician: The law requires that the death certificate be executed and Due to (or as a consequence of): resulting in death) Last attending physician a for use as the burial Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Live Birth 2 LJ Fetal deat
□ Pregnant at time of death in the past 12 months?
1 ☐ Yes 2 ☐ No Day Month Year 5 Other (specify) signed by the at d be detached for Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ğ Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🕱 Unknown plnous 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an ate has bage 2 s autopsy performed' certificate Yes 2 X No 2 No 25. Was case referred to medical the funeral director, Be 26. Place of Death (Check only one) Other: 4 \(\text{Nursing Home} \) 5 \(\text{Residence} \) 6 \(\text{Other} \) Other (Specify) 1 Yes 2 No Certificate: To 1 K Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending work 1 Yes 2 No Accident Investigation Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined

within 24 hours after death.

To the Funeral Director; After this filled in by 6

Medical

29a. Certifier

29b. Signature and title of certifier

MAR U 5 2012

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Irina Y. Ruban, MD 1500 Forest Glenn Road, Silver Spring, MD 20910 31. Date filed (Month, Day, Year) 32. Registrar's Signature

State

Registrar

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29d. Date signed (Month, Day, Year)

March 2, 2012

29c. License number

D63343

2-01684 Iarjorie Savage		Pleas		or Print in Bi of Maryland					_	ible.	100000	
		1- For State Registrar		-	•	cate of De			Reg	. No. 2 U	12 0853	
Physicia Medical Exami									Date of Death Month [-ebruary 27		3. Time of Death 2137 hrs	
		4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Lo Silver Spring					•	of Death 4c. County of Death Montgomery				
Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 1 M 2 X F 56 Yrs					If Under 1 Year If Under 24Hrs. 8. Date of Birth (Months Days Hours Min. 1 0 / 1 9 /			Fo	Birthplace (State or reign Country) Utah	
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23s or 28s-f show any injury or other tranmatic event, the Medical Examiner must be notified at once.	To Be Completed by Funeral Director	Usual Residence of Decedent 10a. State										
		10e. Street and Number 2114 Cascade Road				10f	Zip Code 20902		10g	. Citizen of What C USA		
		11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced or Dates:				13. Was Decedent of Hispanic Origin? (Specify Ye If Yes, specify Cuban, Mexican, Puerto Rican, e 1 Yes 2 No specify:				White, etc. White Specify:		
		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 4				during most of	sual Occupation (Giv working life. DO NO act Nego	OT use retired)	ss/Industry		
		Gordon A.Christenson Kat						ather	ame (First, Middle, Maiden Surname) nerine Demik or Rural Route Number, City or Town, State, Zip Code)			
		Peter K.	Savag	• • • • • • • • • • • • • • • • • • • •	đ	2114 (Cascade	Road	Silver	Spring	,Md 20902	
		20a. Method of Disposit 1 Burial 2 X 4 Donation 6	remation 3 Other Specify		crema	esapeal	ce Crem.	3/2/	2012	20c. Location - City Beltsvi	lle,Md.	
	1. 28	21. Signatu e Funera	D KUM	ille 1							ICE,P.A. ing,Md2091	
Physician Medical Examiner		23a. Part I. Enter the dis failure. List only or Immediate Cause (Fina or condition resulting in	ne cause on ea I disease a.	ach line. Intraoral Gunsh	ot Wound	not enter the mo	ode of dying, such as	s cardiac or re	spiratory arrest	t, shock, or heart	Approximate Interval Between Onset and Death	
B	Completed by Physician	or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):										
		cause. Enter Underlying Cause (Disease or injury that initialed events resulting in death) Last Due to (or as a consequence of):										
be executed sician and transfer transfe		UNPENDED AMENDED										
Division of Vital Records, P.O. Box 68760, Hospital or Attending Physician: The law requires that the death certificate be executed to hours after cleath. Funeral Director: After this certificate has been signed by the attending physician and tely filled in by the funeral director, page 2 should be detached for use as the burial - tran		IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 1										
s, P.O. Be ires that the de signed by the		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 V No 3 Probably 4 Unknown										
of Vital Records, sg.Physician: The law requir After this certificate has been s meral director, page 2 should b		OF W.					00 Plane (Page		24a. Was an autopsy perform	prior death	autopsy findings available to completion of cause of ? Yes 2 No	
Vital hysician this cert	o Be	25. Was case referred to examiner? 1 Yes 2	. it	Hospital: 1 Inpatie	ent 2 ER/	Outpatient 3	26.Place of Dea			esidence 6 🗸 Ot	her: Scene	
ion of tending Phasath. tor: After tor: After to the funeral	ation: T	27. Manner of Death 1 Natural 5 Accident	Pending Investigati	28a. Date of Inju FOUND: FOUND: Feb 27, 2012		. Time of Injury UND: 30 hrs	28c. Injury at Wo	_ Isu	d. Describe ho bject shot s	w injury occurred self		
Division pital or Attendio ours after death. reral Director: A	Certification	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rura or Town, State) 2114 Cascade Drive, Silver Spring, I								Rural Route Number, City		
Divisior To the Hoopital or Attend within 24 hours after death To the Funeral Director: Completely filled in by the	Medical	29a. Certifier (Check only 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.										
D 75	Ž	29b Signature and title of certifier					O.C.M.E.	er		29d. Date signed (Month, Day, Year) February 28, 2012		
		20- Name and address of person who completed cause of death (Item 23a) Laron Locke MD. Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223										
St Regis	ate trar	31. Date filed (Month, D		32. Registra	r's Signature	add.						
	_											

DHMH 17 Rev 1/2001 OCME 2006

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

James R. Scullen, Jr.

2012 08536

		For State	Certificate of Death						_Reg. No.			
Physicia		Decedent's Name (First, Middle,Last)						Date of D Month		Year	3. Time of Death	
ledical Examin	er	James Roche Scullen, Jr.					March 1	0, 2012	real	1921 hrs		
	4	a. Facility Name (if not institution	n, give street and number)		45	o. City, Town, or I	ocation of I	Death	4c. Cou	inty of Death		
		3431 S. Leisure World Blvd. #2B Silver Spring							Montgomery			
Funeral	5	. Social Security Number	6. Sex 7. Age	e (In yrs. last b	irthday)	If Under 1 Year		24Hrs. 8. Date of	Birth(MM/DD/Y	YYY) 9. Birth	hplace (State or Washington,	
Director		577-62-7209	1 X M 2 F	66	Yrs.	Months Days	Hours	Min.	1, 1945		intry) DC	
	H	Isual Residence of Decedent		00		l		purj	-, -,			
*ny	_	10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits										
	.]	MD Mor	ntgomery	C4 1370	r Spri	no					1 Yes 2 X No	
Aaryland 28a-f show	흱	Oe. Street and Number	regomery	DIIVC		10f. Zip Code			10a. Citizen o	of What Coun	try?	
Mar ed a	Director	3431 South Leisure World Blvd. #2B 20906 USA										
th the Maryland 23a or 28a-f sho notified at once.											Division Blood	
th wi	TILL	Marital Status Never Married 2 M	12. Was Decedent Armed Forces?	Ever in U.S.				? (Specify Yes or uerto Rican, etc.)		White, etc.	can Indian, Black,	
or it	ᇍ		1 X Yes 2	No CO 70						_{cify:} Whit	٩	
s afte	21	or Dates:								of Business/Ir		
hour fratu	ᇗᆫ	Elementary/Secondary (0-12)	College (1-4 or 5			st of working life.			TOD. KING	Ji Basii lessiii	laddity	
36 in 72 in 12	mpleted	Elementary/Secondary (0-12)	College (14 of 5		Trans	lator			Dept.	of Ag	riculture	
5-0036 iled within 7 Hygiene. I other than	E	7. Father's Name (First, Middle			TT CITE		8 Mother's	Name (First, Middle				
THYS	9							sa B. Mey				
2121 ould be found be formal marked ic event,	e 1	James Roche S 9a. Informant's Name/Relations		213	9h Mailing	Address (Street		er or Rural Route N		Town State	Zin Code)	
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "autural", or items 23s or 28s-f shu injury or other tranmatic event, the Medical Examiner must be notified at once	- J	Carol A. Darli		- 1	_	•		e, Silve				
MD and 2 sho salth and 27 is		Oa. Method of Disposition	ng/ biscer	20b. Place		ion (Name of cerr		Date		tion - City or		
of He		Burial 2 Cremation	n 3 Removal from Sta	ate crem	atory or othe	er place)		March 19		2	, ,,	
Page Page or or	4	4 Donation 5 Other S	pecify:	Gate		aven Ceme		2012			ring, MD	
Baltimore, bennit. Pages I an Department of He Important: If ite	2	Signature of Funeral Service	Licensee MO1	zm z	Fra	me and Address NCIS J	Colly	ns Funer	al Home	Inc.		
E E D B	1	Joseph 1. C	/ · · · · ·		500	Univers	sity E	31vd. W.,	Silver	: Sprir	ng, MD 20901	
Physician	2	3a. Part I. Enter the disease, or failure. List only one cause	complications that caused on each line.	the death. Do	not enter the	e mode of dying,	such as car	diac or respiratory	arrest, snock, c	or neaπ	Approximate Interval Between Onset and	
√Medical. ≟xaminer		mmediate Cause (Final disease			diovas	cular D	isease	2			Death	
	٥	or condition resulting in death)	Due to (or as a conse	equence of):								
	ا ا	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):										
	ِ ا	cause. Enter Underlying Cause										
_ Q =		(Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):										
		· .	d. AMENDED 23a	27		0.05 2 21	10 -					
<u>a a a</u>	/Medical	X UNPENDED	AMENDED 238	, 27, per	me, g	925 3-21	12 S	111				
760, ficate be g physic the burn	ĕ [,	F FEMALE: Bb. Was decedent pregnant in t	23c. If yes, outcom			- [¬			te of delivery		
68 ertifi ding		past 12 months?	Live bildi	time of death			Ectopic p	pregnancy	Mor	nth D	ay Year	
Box 687; death certificate attending ed for use as t	Physician	Yes 2 No 9 Un	known 9 Unknown	unic or dodar	5 Othe	er (Specify)						
that the de ned by the detached for	ᇍ	Part II. Other significant condi		hut not result	ting in the un	dedving cause o	iven in Part	1 23e. Di	d tobacco use	contribute to t	he cause of death?	
, P.O. res that the signed by be detach	<u>آ</u> ھ	•		1 Yes 2 No 3 Probably 4 Unknown								
G, Landeres	ē								as an 2	4b. Were aut	topsy findings available	
ords, aw requir as been s	Completed							au	topsy		ompletion of cause of	
Rec The la	E	performed? death? 1 ✓ Yes 2 No 1 ✓ Yes 2 No										
tal Rection: The certificate ector, page	2	5. Was case referred to medica						heck only one)				
Vital ysician:	0	examiner? 1 ✓ Yes 2 No	Hospital: 1 Inpatie	ent 2 🔲 ER	/Outpatient	3 DOA	Other ₄ 🔲 ı	Nursing Home 5	Residence	6 🗸 Other:	Scene	
o ≥ e e e e	2	7. Manner of Death	28a. Date of Inju (Month, Day,Y	iry 28i	b. Time of Inj	jury 28c. Injur	y at Work?	28d. Descrit	e how injury o	ccurred		
OD tendin	ΞI		ding	,		1 Y	es 2 N	1 0				
Division safer death. In Director: A led in by the fu	<u>≅</u>		estigation 28e. Place of In	jury - At home	, farm, street	, factory, office b	uilding, etc.			lumber or Rur	ral Route Number, City	
Divi	린	Suicide Could not be or Town, State) 4 Homicide determined (Specify)										
Divi	R 2	29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.										
To the Hos within 24 h To the Fur completely		one) 2 Medical Exa	aminer:On the basis of examiner stated.	mination and/o	or investigation			urred at the time, da	ate and place, a	and due to the	cause(s)	
H 3 H 8	2	29b. Signature and title of certifier 29c. License number							29d. Date signed (Month, Day, Year)			
		O.C.M.E.							March 11, 2012			
20+1-PEX	עי	30. Name and address of person who completed cause of death (Item 23a)										
	Donna M. Vincenti, MD Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223											
Sta	ate 3	31. Date filed (Month, Day, Year,	2. Registra	r's Signature	had	0.						
Regist	ar	MAR 142	UTZ Reman	B. A.	70000	AVE.						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician/ Robert Elsworth Schimpf 2012 February 1:30 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death FutureCare - Chesapeake Anne Arundel Arnold 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Social Security Number **Funeral** Months Days Min Hours Director 212-32-6402 Usual Residence of Dece 1 🗶 M 2 🗆 F 77 Yrs July 15, 1934 Maryland 28a-f show 10a. State 10c. City, Town or Location 10d. Inside City Limits with the Maryland at 10b. County Director notified MD Anne Arundel Severna Park 1 Yes 2 X No 10e. Street and Number 9 10f. Zip Code 10g. Citizen of What Country? ms 23a or must be n Funeral 814 Cypress Beach Road items death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 No 1957 14. Race - American Indian, Examiner Black, White, etc. 6 þ 1 Never Married 2 Married 1 X Yes 2 If Yes, Give Year or Dates. Maryland 21215-0036 Page 1 and 2 should be filed within 72 hours after 1 ☐ Yes 2 🔀 No Specify: Specify "natural" Completed 3 X Widowed 4 ☐ Divorced White Medical Decedent's Education Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working I Hygiene. life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) the Drummer Music 12 ulth and Mental Hygie 27 is marked other r traumatic event, th Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Frederick John Schimpf Elsie Johanna Haase 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) of Health a Richard J. Schimpf/Brother 1396 Rainbow Drive Pasadena, MD 21122 other altimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State of cemetery, crematory or other place) Department of Important: If i any injury or o 1 Burial 2 X Cremation 3 Removal from State Feb 2012 Metro Crematory Baltimore, MD 4 Donation 5 Other (Specify) 21. Signal te of Fun, a Service Liv n Barranco & Sons, P.A. Severna Park Funeral Home 495 Ritchie Hwy. Severna Park, MD 21146 23a. Part 1 criter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Ph.sician/ alli disease or condition Medical resulting in death) Examiner lar Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Examine burial-transit Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) the attending physician Physician/Medical certificate be P.O. Box 68760 the use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ctopic pregnancy
5 Other (specify) Hospital or Attending Physician; The law requires that the death 24 hours after death.
Funeral Director: After this certificate has been signed by the atter in the past 12 months?

1 Yes 2 No Month Day Year Pregnant at time of death should be detached signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has page 2: autopsy performed? Yes 2 No 1 Yes 2 No 25. Was case referred to medical funeral director, Be 26. Place of Death (Check only one) examiner? Other: 4 X Nursing Home 5 - Residence 6 - Other (Specify) 1 Yes 2 🗷 No ပ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 1 X Natural 5 Pending 1 Yes 2 No Accident Investigation filled in by the Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number City or Town, State) 4 Homicide determined Medical 29a. Certifier 1 🛣 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the 1 within 2 To the 1 3 29b. Signature and title of certific 29d. Date signed (Month, Day, Year, 23.72 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar
DHMH 17 Rev 06-2011

State

tandove.

MD

eterou

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Glenn Month Day Year Scott 17:03 am Medical 2019 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death County of Death Examiner Glen nner Himorellas nato If Under 1 Year If Under 24 Hrs. 8. Date of Birth Social Security Number 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 X M 2 🗆 F Hours 6/297 Py547 PENNSYLVANIA 57 **Director** 200-46-6827 Usual Residence of Decedent 28a-f shov 10c. City, Town or Location 10d. Inside City Limits Examiner must be notified at Director 1 Yes 2 XNo MD ANNE ARUNDEL CROFTON ö 10e. Street and Number 10f. Zip Code 10a. Citizen of What Country? Funeral "natural", or items 23a 1516 HORNBEAM DRIVE 21114 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, ģ 1 Never Married 2 X Married 1 ☐ Yes If Yes, Give 1 ☐ Yes 2 🕅 No Specify. Saltimore, Maryland 21215-003 3 Widowed 4 Divorced Specify:WHITE Completed Year or Dates permit. Page 1 and 2 should be filed within 72 hour Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturany injury or other traumatic event, the Medical any injury or other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 12 ACCOUNT EXECUTIVE Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ WILLIAM SCOTT LOIS LOGAN 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) KAREN DOWNIE-SCOTT/WIFE 1516 HORNBEAM DRIVE CROFTON, MD 21114 20a. Method of Disposition 20b. Place of Disposition (Name of 1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) CHESAPEAKE CREMATION CENTER 2/29/2012 STEVENSVILLE

22. Name and Address of Facili LASTING TRIBUTES FELLOWS, HELFENBEIN & NEWNAM CREMATION & FUNERAL CARE 814 BESTGATE ROAD ANNAPOLIS, MD 21401 Signature of Funeral Service Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onse and Death Immediate Cause (Final Physician/ multisydem disease or condition Medical resulting in death) **Examiner** cirrhos 6716 Sequentially list conditions, cause. Enter Underlying Cause (Disease or linjury Due to for as a consequence of, for use as the burial-transit that initiated events Due to (or as a consequence of) resulting in death) Last signed by the attending physician be detached for use as the buria Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? Day Pregnant at time of death 5 Other (specify) 2 🗌 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by and bleed, acute respiratory 2 No 3 Probably 4 Unknown cate has been sig ; page 2 should b 1 Yes 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy perform To the Hospital or Attending Physician: The I within 24 hours after death.

To the Funeral Director: After this certificate I completed filled in by the funeral director, page 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 No ပ 1 Impatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work?
1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred Natural 5 Pending 2 Accident
3 Suicide
4 Homicide Accident Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29b. Signature ar 29c. License number 29d. Date signed (Month, Day, Year, m ted cause of death (Item 23a) (Type, Print Dr. Glen Burni, MD 2106 305 A CUAS My.

Registrar
DHMH 17 Rev 7/2009

State

31. Date filed (Month.

FEB 2 9 2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Grace Joan Simmons February 28, 2012 8:45 A M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 1009 Jackson Street Annapolis Anne Arundel Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days Hours (Month, Day, Year) Months 094-12-7919 91 **Director** 1 M 2 XX Yrs. Nov. 4, 1920 New York Usual Residence of Decede 28a-f shov 10b. County aţ 0a. State 10c. City, Town or Location 10d, Inside City Limits Director notified Maryland Anne Arundel Annapolis 1 X Yes 2 No ö 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ral", or items 23a or Examiner must be 1009 Jackson Street Funeral 21403 U.S.A. 12. Was Decedent Ever in U.S Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married Yes 2XXNo Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 🏋 No Specify. Specify: White "natural", Completed 3 X Widowed 4 Divorced the Medical Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working Hygiene. life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Secretary State Government 12 e 1 and 2 should be filed wit of Health and Mental Hygie If Item 27 is marked other or other traumatic event, the Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Anthony Burton Stephany Clotilda Bertha Mosley 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health an Important; If Item 27 is any injury or other trau Danny Simmons/son 522 Tayman Drive Annapolis, Maryland 21403 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State emetery, crematory or other place) 1 Burial 2XXCremation 3 Removal from State Baltimore Crematory 3/2/2012 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility John M. Taylor Funeral Home Signal 147 Duke of Gloucester St., Annapolis, MD 21401 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Colon cancer Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease Onlinjury that initiated events Due to (or as a consequence of): requires that the death certificate be executed and I-tran Due to (or as a consequence of): resulting in death) Last burialphysician Physician/Medical Box 68760 attending pl IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months? Month Day Year Pregnant at time of death 2 **X X**No the 9 Unknown 9 Unknown P.0. signed by t Part II, Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e, Did tobacco use contribute to the cause of death? à Division of Vital Records, 1 ☐ Yes 2XXNo 3 ☐ Probably 4 ☐ Unknown been sig Completed 24a. Was an Were autopsy findings available prior to completion of cause of page 2 s autopsy perform death? certificate 2 No 2 X No Yes Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Be Hospital: Other: 2**XX**No ဂ္ 1 Yes 4 Nursing Home 5 X Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 IDOA After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 28b. Time of Certificate: 28d. Describe how injury occurred Hospital or Attending 24 hours after death. 1XXNatural 5 Pending injury 1 Yes 2 No Accident Suicide Investigation Director: / 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) filled Funeral Medical 29a. Certifier 1 Sertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

State

Ruth Gallatin, MD 31. Date filed (Mo MAR 0 1 2012

(Check

only one)

29b. Signature ap title of certifier

445 Defense Highway Annapolis, Maryland egistrar's Signature

and address of person who completed cause of death (Item 23a) (Type, Print)

Ms

Registrar

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

D0052089

29d. Date signed (Month, Day, Year)

February 28, 2012

29c. License number

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ PATRICIA LYNN MARCH SULL IVAN-COCHRAN 2:28 P M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death FREDERICK FREDERICK FREDERICK MEMORIAL HOSPITAL Social Security Number 7. Age (In yrs. last birthday, Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) **Funeral** 9. Birthplace (State or Foreign 1 □ M 2 🕅 F Hours Min. 1958 MOROCCO 53 222-44-9665 Director AUG 14 Usual Residence of Decedent 28a-f sho 10b. County MONTGOMERY Oc. City, Town or Location with the Maryland 10d. Inside City Limits Director must be notified 1 Yes 2 No 10e. Street and Number ō 10f. Zip Code 10g, Citizen of What Country? 23a Funeral 27460 Apt. B CLARKSBURG RD. 20872 UNITED STATES items filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2X No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black, White, etc. ŏ þ 1 Never Married 2 Married ☐ Yes Yes, Give Maryland 21215-0036 1 ☐ Yes 2X No Specify: WHITE "natural" 3 Widowed 4 Divorced Specify: Completed Year or Dates Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) other than College (1-4 or 5+) the BANKER BANKING Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) of Health and Mental H f item 27 is marked ot r other traumatic ever ၉ JAMES JOHN SULLIVAN Page 1 and 2 should be GISELE BENAIM 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, KEITH COCHRAN/ HUSBAND 27460 APT. B CLARKSBURG RD. DAMASCUS MD 20872 Department of Healt Important: If item 2 any injury or other Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other r 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 XCremation 3 Removal from State SMITHSBURG CREMATORY 03/14/2012 4 Donation 5 Other (Specify) SMITHSBURG, MD Signature of Funeral Service $^{22.\,\text{Name}}$ and Address of Facility KEENEY $106\,$ E. CHURCH ST. FRE NEY & BASFORD FUNERAL HOME FREDERICK, MD 21701 M0164623a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Conset and Death Immediate Cause (Final Ph_sician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner NEUMONIA Sequentially list conditions, Examine Due to (or as a consequence oi) if any, reading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events and burial-tran Due to (or as a consequence of) resulting in death) Last sate has been signed by the attending physician page 2 should be detached for use as the burial Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physicis. P.O. Box 68760 IF FEMALE yes, outcome of pregnancy

Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 month 1 Yes 22 No Month Day Pregnant at time of death g 🗌 Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 2 No Completed 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy perform Yes 2 No funeral director, 25. Was case referred to medica Certificate: To Be 26. Place of Death (Check only one) examiner? Other: 4 \square Nursing Home 5 \square Residence 6 \square Other (Specify) 2 XNo 1 npatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at 28b. Time of 28d. Describe how injury occurred Natural Accident 5 Pending 1 Yes 2 No Investigation 6 Could not be completed filled in by the 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, geath occurred at the time, date and place, and due to the cause(s) and manner as stated.

☐ Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 29b. Signature and title of certifier 29d, Date signed (Month, Day, Year,

State

Registrar

31. Date filed (Month, Day, Year)

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

anilford

MD 51610

21704

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 02723/2012 10:50 AM David Shuster Malcolm Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death Examiner 4c. County of Death The Casey House Rockville Montgomery 5. Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** Days Months Hours Min 07/93th Pay 943 014-34-5080 1 ₺ M 2 □ F 68 **Director** MA 28a-f show 10a. State 10b. County Page 1 and 2 should be filed within 72 hours after death with the Maryland items 23a or 28a-f sho ner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 No MD Montgomery Bethesda 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7501 Democracy Blvd #414 20817 United States Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 Yes 2 No
If Yes, Give Black, White, et P à 1 X Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify. White Specify. "natural" 3 Widowed 4 Divorced Completed Year or Dates Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than 'any injury or other traumatic event, the Meany once. College (1-4 or 5+) Elementary/Secondary (0-12) Physicist Federal Government Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Sarah Bela Sharfman Samuel Joseph Shuster 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Andrew S. Lerner - friend 1010 Bayridge Terrace Gaithersburg, MD 20878 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 $\!X\!\!$ Burial 2 $\!\square$ Cremation 3 $\!\square$ Removal from State Garden of Remembrance 03/02/12 Clarksburg, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Line insec 22. Name and Address of Facility M01163 Danzansky-Goldberg Memorial Chapels Inc 1170 Rockville Pike Rockville MD 20852 Jamie Arthurs 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Ph sician/ disease or condition resulting in death) Acute Respiratory Failure Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) attending physician and I for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE ves, outcome of pregnancy

Live Birth 2 Fetal death 3 Ectopic pregnancy

Pregnant at time of death 5 Other (specify) 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? b Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🔀 Unknown Hypoventilation Syndrome 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Carbon Dioxide Narcosis has le 2 r this certificate has eral director, page 2 performed? Yes 2 No COPD 2 🗆 No 1 Tes Was case referred to medical Be 26. Place of Death (Check only one) examiner?
1 Yes 2 No Hospital Other: ျ 4 Nursing Home 5 Residence 6 Nother (Specify) Hospice 1 Inpatient 2 ER/Outpatient 3 I 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred X Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide determined 24 hours Medical 29a Certifie Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check To the within 2 3 🔀 Certifying Nurse Practitioner. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29d. Date signed (Month, Day, Year) 143201 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Deborah Miller - 6001 Muncaster Mill Rd., Rockville, Maryland 20855

DHMH 17 Rev 06-2011

State

Registrar

31. Date filed (Month, Day, Year)

MAR 12 2012

Amend #10b,per FD, 3/12/12, CCHD,drw

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible

\cap	0	jong lim	1.	
U	0	Ü	Lab	6

2/12/		For		State of	of Maryla		partment			and M	ental Hy	giene	>	f from		
		State Registrar	a (First Middle	(act)		C	ertificate	of D	eath_		2. Date of Dea	Reg. No	э.		2 Time	of Death
Physicia Medic			William	n Sherro		on, Jr					Month	26, Da	2012	Year		:09 M
Examin	er	4a. Facility Name (if					4b. City, To			f Death			c. County o		11	
Funeral		Anne Ar 5. Social Security N		Medical C	enter 7. Age (In vi	rs. last birthda	y) If Under 1		If Under 2		8. Date of Birl	th.	nne <i>l</i>	9. Birthp	lace (State	or Foreign
Director		218-34-7		1 🙀 M 2 🗆 F	73	Yrs	Months L	Days	Hours	Min.	Month, Da. March		938	NC	ry)	
ow t	_	Usual Residence		Charles		City, Town or	Location				narch .		750		Od. Inside	City Limits
irylane	Director	Maryland	,	daries			tte Hali	1								es 2 X No
or 28;		10e. Street and Nur					10f. Zip C	ode				10g. C	itizen of W	hat Coun	try?	
with t	Funeral	7710 Ar	bor Vie	ew Drive			20	0622	2			U.	S.A.			
permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Merfall Hygiene. Department of Health and Merfall Hygiene. Department of Health and Merfall Hygiene. It is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	by Fun	11. Marital Status		12. Was Dec Armed Fo ied 1 🔀 Yes	orces? 2 \(\subseteq \text{No} \)	U.S. 1	3. Was Deceden	Cuban	, Mexican,	gin? (Spec , Puerto F	ify Yes or No- lican, etc.)		Black	- America , White, e	etc.	
ours aft atural", cal Exa	Completed I	3 XWidowed		If Yes, Gir Year or D		16a. De	1 Yes 2 cedent's Usual C	Occupat	tion			16b.	Specify: Kind of Bus	Whi siness/Inc		
in 72 h e. an "n Medi	ldmc	(Spe	ecify only highe	st grade completed College ((Gi	ve kind of work of DO NOT use re	done du etir e d)	iring most	of workin	g		ion 1			
d with lygien ther th	Be Co	8		41		Cra	in Oper				(First, Middle,					_
d be file	To B	17. Father's Name (rod Tyso	n, Sr.				M M	lary	Washin;	gton	l			
2 shouk th and N 27 is ma trauma		19a. Informant's Na					ailing Address (S 3 Batte							ate, Zip C	lode)	
of Heali of Heali if item 2		20a. Method of Dis	position	3 Removal fron		b. Place of Di	sposition (Name crematory or other	of	1	larch	ate 6	20c. L	_ocation -			
artment ortant: injury o			5 Other (S	pecify)	M	MD Vete	ran's C		terý	20	12		ltenl			
permil Depar Impor any in		15 Ga	ry J. (Goff			8200 J	enn:	ifer	Lane	, Owing	gs,		20736		
Physician/		shock, or hea Immediate Cause	art failure. List c (Final	complications that only one cause on e	caused the cach line.	death. Do not	enter the mode of	of dying	, such as c	cardiac or	respiratory ar	rest,			Approxim Interval B Onset and	Between
Medical Examiner		disease or condition resulting in death)		a. Due to	(or as a cons	sequence of):	seps sic	, ,	1116	1 1	10	-/	· nea!	1.6		
- 3	ner	Sequentially list co	nmediate	b. Due to	(or as a cons	sequence of):	sep à		10/1	ng	ecueer	CF 1	16141	7260		
scuted and -transit	Examiner	cause. Enter Unde Cause (Disease or that initiated event resulting in death)	injury ts	c. Due to	(or as a cons	sequence of):	Aic		Ha	1 ole	DELD			\rightarrow		
ate be executed physician and the burial-transit	edical E	resulting in death)	Lust	L d		Be	and	er	mi 6	2						
ificate ng phy as th		IF FEMALE:										Ĩ				
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transt	Physician/M	23b. Was decedent in the past 12 1 Yes 2 9 Unknowr	months? □ No		e Birth 2 🗆 gnant at time	Fetal death	3		′				23d. Date Mor	e of deliventh	ery Day	Year
that the led by t detack	by Phy			ons contributing to			ne underlying ca	use give	en in Part 1	1.	23e. Did t	obacco	use contri	bute to th	ne cause o	f death?
uld be	ed b	atua	el t	isnella	xto	u					1 🗆	Yes 2	2 No	3 🗌 Prob	pably 4]	Unknow
law rec has bee ge 2 sho	Completed	Lung	Car	way	EIP K	RUL	Cospet	on	y.		24a. Was auto		р	rior to colleath?	mpletion o	s available of cause of
n: The ficate or, pag	ပို မ	25. Was case refer	red to medical	PRCI	9 5 te	nta	nd Ch	76 Pla	ce of Deat	th /Check	only one)	2 🗆 1	No 1	Z Yes	2 🗌 No	
/sicial s certi direct	To Be	examiner?	□ No	Hospital:	Inpatient 2	P ☐ FR/Outpa	atient 3 DOA	Othe	P1		me 5 Resi	dence	6 Othe	r (Specify	·)	
ng Phy ter this uneral		27. Manner of Deat	th 5 Pendir	28a. Date	e of injury nth, Day, Yea.	28b. Tim	e of 28d	c. Injury work?	at	2	28d. Describe					
ttendil death. tor: Al	Certificate:	2 Accident	Investig	gation	f l- i 0	\h.	M dreat featons		Yes 2 🗆		28f. Location (Stroot a	nd Numbe	r or Rura	I Route Nu	mber
al or At s after o	Cert	4 \square Homicide	determ		e of injury - A ding, etc. (Spe		street, factory, o	onice		1	City or To			r or nurar	noute rva	riber,
Hospita 24 hours Funeral etely fille	Medical	(Check	2 Medical B	Physician: To the Examiner: On the ba Nurse Practitions	asis of examin	ation and/or in	vestigation, in my	v opinior	n, death oc	ccurred at	the time, date	and plac	ce, and due	to the ca	use(s) and	manner stat
To the within To the comple	Σ	only one) 29b. Signature and		7 /	. TO THE DESI	OI HIJ KITOWIE	$\overline{}$	License		unu pia	23, 4.14 446 10		ate signed			
)		A	ady /	fere	the 1	Hent	ELLI)	43	37	/		52	126	2/1	2	113.1
41 W		30. Name and add	ress of person	who completed call	best	(Item 23a) (Typ		1	994cr	nc	French	ozi	maa 1, m	d.	214	01
Stat Registra		31. Date filed (Mon	nth, Day, Year)	3-2 2012	Registra s Si	ignature /	1. par	es.			,					
			1171	The Part of State	- James C.											

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For	State of Marylan				1ental Hyg	giene	2 0051.3
		_	State Registrar		Cer	tificate of D	Death		Reg. No. 4 U	2 00343
	Physicia	in/	Decedent's Name (First, Middle, Last	· · · · · · · · · · · · · · · · · · ·				Date of Dea Month	Day Ye	3. Time of Death
	Medic	cal	4a. Facility Name (if not institution, give s	I Q V I O Y		4b. City Town or	Location of Death	Feb.	7	12 1:10PM
	Examin	ier	3378 LVnd	ale Avenu	B	45. City, Jown, or	1 4		4c. County of D	peath
	Funeral		5. Social Security Number 6. Se	x 7. Age (In yrs. la		If Under 1 Year	If Under 24 Hrs.	8. Date of Birth	9.	Birthplace (State or Foreign
	Director		214-20-83/31	□M218F 78	Yrs.	Months Days	Hours Min.	July 3	Year 933 1	Jary land
} -	show d at	٦	Usual Residence of Decedent 10a. State 10b. County	10c. City	, Town or Lo	cation		/ .	1,000	10d. Inside City Limits
	laryla 3a-fs :ified	ect	MD	14	Balt	more.				1 🖫 Yes 2 □ No
Q.	or 28	اقّ	10e. Street and Number		(4) (1)	10f. Zip Code			10g. Citizen of What	t Country?
6	is 23a	Funeral Director	3328 Lynda	le Avenue		2/2	13		215A	
7	deatt		11. Marital Status	12. Was Decedent Ever in U.S Armed Forces?	i. 13. V	Vas Decedent of Hi Yes, specify Cuba	spanic Origin? (Spen, Mexican, Puerto	cify Yes or No- Rican, etc.)		American Indian, /hite, etc.
36	all", or	d b	1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	1 ☐ Yes 2 ⅣNo If Yes, Give Year or Dates.	1	☐ Yes 2 ☐ Ño	Specify:		Specify:	21261
21215-0036	natur lical E	Completed by	15. Decedent's Ed	ucation	16a. Deced	lent's Usual Occupa	ation		16b. Kind of Busine	ess Industry
218	in /2 ie. han "l	dwo	(Specify only highest grade Elementary/Seconday (0-12)	College (1-4 or 5+)	(Give I life. Do	rind of work done d O NOT use retired)	luring most of worki	ng		,
7	d with hygien ther ti	Be C				1aNag				ernment
anc	be filed within /2 hours after death with the Mary ental Hygiene. "hatural", or items 23a or 28a-4 ked other than "hatural", or items 23a or 28a-4 ic event, the Medical Examiner must be notifie	To E	17. Father's Name (First, Middle, Last)	alank			18. Mother's Name	e (First, Middle, I	Maiden Surname)	
	2 should the and Me 27 is mark traumati		19a. Informant's Name/Relationship (Ty)	OlocK pe, Print)	19b Mailir	n Address (Street a	and Number or Rura	e. Y Il Route Number	City or Town, State	Zin Code)
Ž	alth au alth au 27 is ertrau		Maxtu Tay	lor	356	7 June		StiMor	0.4	2/2/3
ore,	of Heal of Heal fitem ?		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐	20b. P	lace of Dispo	sition (Name of natory or other place	/	Date	20c. Location - City	
Ĕ.	Page 1 ment of ant: If it ury or o		4 Donation 5 Other (Specify	Memovar nom State	nersk	a ' J	1 : 0 / 0	8/12	Church	Creek, MD.
Baltimore,	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Important: I firem Z7 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		21. Signature of Funeral Service License	;e _ / /	22	Name and Addres	neval Ho	Me, P.A.	, , ,	
	00 = 0 O		23a. Part 1. Enter the disease, or comp	Henry	5	10 Wash	nington	Str Can	Abridge,	
V. 64			shock, or heart failure. List only on Immediate Cause (Final	e cause on each line.	i. Do not ente	ar the mode or dying	y, such as cardiac c	ir respiratory arre	551,	Approximate Interval Between Onset and Death
)	nysician/ Medical		disease or condition resulting in death)	a. Due to (or as a consequence	nce off:					
E	Examiner			Drycytia	erice oi).					
		iner	Sequentially list conditions, if any, leading to immediate	b. Due to (or as a consequ	ence of):					
to to	nd nd transit	Examiner	Cause (Disease or linjury that initiated events	с						
- 0	ohysician and the burial-transit	dical E	resulting in death) Last	Due to (or as a consequ	ence of):					
760 1	physi the b	edic		d						<u> </u>
89	nding use as	n/M	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregnar	ncy	1			23d. Date of	delivery
Box 687	e attel	sicia	in the past 12 months? 1 ☐ Yes 2 ☒ No	1 Live Birth 2 Feta 4 Pregnant at time of d		Ectopic pregnanc Other (specify)	у		Month	Day Year
P.O. E	by the	Physician/Me	9 Unknown	9 ∐ Unknown						
o .	igned be de		Part II. Other significant conditions co	HUCHIVE F		, 0	en in Part I.			e to the cause of death?
rds	equil ponld	etec			OVVIC	ward r	100000			
Records,	has b	Completed by	Viologes In	ellitus				24a. Was a autop:perfor	sy prior	autopsy findings available to completion of cause of h?
<u> </u>	certificate has blirector, page 2 s		25. Was case referred to medical			26 Pla	ace of Death (Check	1 Yes	2 No 1 🗆	Yes 2 No
	is cert direct	To Be	examiner? 1 Yes 2 No	lospital:	ER/Outpatier	Othe)r-	1.	ence 6 Other (S	pecify)
jo d	fter th		27. Manner of Death 1 Natural 5 Pending	28a. Date of injury (Month, Day, Year)	28b. Time of injury	28c. Injury work	at		ow injury occurred	
ion	death. tor: A the fu	Certificate:	2 Accident Investigation 3 Suicide 6 Could not be				Yes 2 No			
Division of Vital	after of Direction by		4 Homicide determined	28e. Place of Injury - At ho building, etc. (Specify)		eet, factory, office		28f. Location (Si City or Town		Rural Route Number,
	The transplant area of the form of the for	ledical		ician: To the best of my knowle						
HOH	in 24 he Fu	Med	(Check 2 Medical Examinonly one) 3 Certifying Nurs	ner: On the basis of examination e Practioner: To the best of my	and/or invest knowledge, o	igation, in my opinio leath occurred at the	n, death occurred at e time, date and plac	the time, date are, and due to the	nd place, and due to to cause(s) and manner	the cause(s) and manner stated. r as stated.
_ =	Ω		29b. Signature and title of certifier			29c. License			29d. Date signed (Mo	onth, Day, Year)
	5		Mars	surp		KI	92808	3	2/20	1/3013
_			30. Name and address of person who co	ompleted cause of death (Item	23a) (Type, F	Print) Anne	- lewi	SICRY	9.	21300
	Sta	te	 Date filed (Month, Day, Year) 	32. Registrar's Signat	ure	1	our l	urkle,	M	7
ļ.,	Registra		MAR 0 8 2012	Buya B.	gar					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Year 2 Marc Day 0254 Physician/ Dulcie Linthicum Thamert 01 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** DORC Cambridge General If Under 1 Year | If Under 24 Hrs. 9. Rirthplace (State or Foreign 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** Dec. II Min. Days 1 🗆 M 2 🔀 F Maryland 213-22-5257 83 **Director** Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mential Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f shov any injury or other traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits 10c. City, Town or Location 10a. State Director 1 X Yes 2 No MD Cambridge Dorchester 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral USA 800 Maryland Avenue 21613 Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Was Decedent Ever in U.S. 11. Marital Status Armed Forces Black, White, etc. þ 1 Never Married 2 Married 1 ☐ Yes If Yes, Give 2 🗶 No 215-0036 white 1 ☐ Yes 2X No Specify. Specify: 3 X Widowed 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation 16b. Kind of Business Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) flower shop manager Be 18. Mother's Name (First, Middle, Maiden Surname) Maryland 17. Father's Name (First, Middle, Last) ပ Ray W. Sheets Elizabeth Robbins 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) P. O. Box 375, Cambridge, MD Craig S. Linthicum son Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 Cremation 3 Removal from State Dld Trinity Churchyard 3/5/12 Church Creek, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Thomas Funeral Home P.A. Signature of Funeral Service Licensee 700 Locust St., Cambridge, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Arteriosclerdhz Cardieralcula Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of Examiner Sequentially list conditions. Due to (or as a consequence of) Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events Due to (or as a consequence of): resulting in death) Last Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 months? Month Dav Pregnant at time of death ☐ Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? 268 Muchua 1 ☐ res 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy performed 1 Yes 2 W 26. Place of Death (Check only one) 25. Was case referred to medical Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 4 No 1 Inpatient 2 ER/Outpatient 3 DOA မ 28b. Time of 27. Manner of Death 28a. Date of injury 28d. Describe how injury occurred 28c. Injury at Certificate: (Month, Day, Year) 1 Natural 5 \square Pending 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical

State Registrar

31. Date filed (Month, Day, Year)

29b. Signature and title of certifie

29a. Certifier

32. Registrar's Signature

303

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Continuing Nurse Practiculars. The basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Continuing Nurse Practiculars.

29c. License number

29d. Date signed (Month, Day, Year)

-2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State Registrar	tate of Maryland		irtment of H <i>tificate of D</i>			giene Reg. No. 2	012	08545
	Physicia	n/	1. Decedent's Name (First, Middle, Last)					2. Date of De Month		Year	3. Time of Death
	Medic	al	Mildred Irac 4a. Facility Name (if not institution, give stree)			4. 07. 7-	Lauria et Da	02	24	2012	6:15 am
may della	Examir	er	6716 Crafton Lane	and namber)		4b. City, Town, or	Clinto		4c. County		orge's
	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. la	st birthday)	If Under 1 Year Months Days	If Under 24 He Hours Mi			9. Birthpl Count	ace (State or Foreign
	Director		577-32-3927 1 □ M Usual Residence of Decedent	² XF 85	Yrs.			July 1	7,1926	Wash	ington,DC
	yland f shov ed at	tor	10a. State 10b. County	10c. City	, Town or Loc		.1.2			10	d. Inside City Limits
	ne Mar or 28a notifi	Director	DC 10e. Street and Number			10f. Zip Code	ashingt	.on	10g. Citizen of	What Count	1 X Yes 2 No
	with the same same same same same same same sam	Funeral	1220 12th Street	. NW			20005		rog. omzor or		8.A.
	death ritems ner m		11. Marital Status 12. V	Was Decedent Ever in U.S Armed Forces?		/as Decedent of His Yes, specify Cubar	spanic Origin? (, Mexican, Pue	Specify Yes or No- erto Rican, etc.)		e - America ck, White, e	
036	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show my injury or other traumatic event, the Medical Examiner must be notified at once.	ed by	2 M W 4 D D D D	l ☐ Yes 2 ᠓ No f Yes, Give √ear or Dates.	1	☐ Yes 2 🗓 No	Specify:		Specify		Black
2-0	2 hour "natu edical	Completed	15. Decedent's Educati (Specify only highest grade co		(Give k	ent's Usual Occupa ind of work done de		orking	16b. Kind of B	usiness/Ind	ustry
121	within 7 giene. er than , the M	Com	Elementary/Secondary (0-12)	College (1-4 or 5+)		NOT use retired) tive How	se Keep	er		Dome	stic
nd 2	be filed w ental Hyg ked othe ic event,	Be	17. Father's Name (First, Middle, Last)	2				ame (First, Middle,		e)	
yla	should be file and Mental I 7 is marked or raumatic eve	은		rd Coleman					Greene		
Ma	12 sho lith and 27 is r r traun		19a. Informant's Name/Relationship (Type, P Delores Barham - Da		1	g Address (Street a Crafton					
Baltimore, Maryland 21215-0036	permit. Page 1 and Department of Heal Important: If item 3 any injury or other		20a. Method of Disposition	20b. Pl	lace of Dispos	sition (Name of latory or other place		Date	20c. Location		
ij	t. Page tment tant: I		1 X Burial 2 ☐ Cremation 3 ☐ Rem 4 ☐ Donation 5 ☐ Other (Specify)	Resu	vrect	ion Cemet	ery 03/				
Bal	permit. Page . Department or Important: If any injury or once.		21. Signature of Funeral Service Licensee	ug woon	J 11	Name and Address 800 New f	s of Facility f Jampshi	lines-Rin re Ave.,S	aldi Fur Silver S	reral pring	Home, Inc. ,MD 20904
	Physician Medical Examiner bhysician and sthe private	edical Examiner	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last d	Due to (or as a consequence of the to (or as a consequence of		Can					Onset and Death
. Box 68760	To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending phy completely filled in by the funeral director, page 2 should be detached for use as the	Physician/Med	in the past 12 months?	f yes, outcome of pregnar	Ideath 3 ∟	Ectopic pregnancy Other (specify)	/			ate of delive	ry Day Year
ds, P.O.	quires that the en signed by ould be deta	by	Part II. Other significant conditions contrib	uting to death but not resu	ulting in the ur	nderlying cause give	en in Part I.				e cause of death?
Division of Vital Records,	sing Physician: The law re h. After this certificate has be funeral director, page 2 sh	Completed	25. Was case referred to medical			00.70		24a. Was auto perfo 1 Yes	psy	Were autop prior to con death? 1 Yes	sy findings available inpletion of cause of
Vita	Physicia this certi ral direct	To Be	examiner? 1 \(\text{Yes} 2 \text{No} \) No	tal:	ER/Outpatien	Othe	ce of Death <i>(Ch</i> r: 4 Nursing		dence 6 🗆 Oth	er (Specify)	Vaugnter's Residence
ot	ing Ph	ate:	27. Manner of Death 1 Natural 5 ☐ Pending	8a. Date of injury (Month, Day, Year)	28b. Time of injury	28c. Injury work?		28d. Describe I	now injury occurr	ed	
isior	To the Hospital or Attending I within 24 hours after death. To the Funeral Director: After Completely filled in by the funer	Certificate:	2 Accident Investigation 3 Suicide 6 Could not be 4 Homicide determined	8e. Place of Injury - At hor	me, farm, stre		Yes 2 □ No		Street and Numb	er or Rural I	Route Number,
2	oital or ours aft eral Dir			building, etc. (Specify)				City or Tov		_	
	e Hospital 124 hours e Funeral	Medical	29a. Certifier 1 Certifying Physician (Check 2 Medical Examiner: Conty one) 3 Certifying Nurse Page		and/or investi	gation, in my opinior	n, death occurre	d at the time, date a	and place, and du	e to the cau	se(s) and manner stated.
	To the vithin 2 To the Comple	2	29b. Signature and title of certifer	7)		29c. License	number		29d. Date signe	d (Month, D	ay, Year)
	5			ANP-	BC	Aco	0093	7	Februar	-y 2	9,2012
			30. Name and address of person who complete Reynold	I ANP - T	23a) (Type, P	7200 T	basil	C+ S+	e 200	Lar	9, 2012 90 HD 207
	Sta Registr		31. Date filed (Month, Day, Year) MAR 0 2 2012	32. Registrar's Signatu	A CALL	,					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

	_ FOI	partment of Health and N	Mental Hygiene	0 00516
	riogistical	ertificate of Death	Reg. No. 2	2 08546
Physician	1. Decedent's Name (First, Middle, Last) Lee Ellen Parzow Thompson		2. Date of Death Month Pay February 27, 20	3. Time of Death 12:50 P M
Medica Examine		4b. City, Town, or Location of Death Bowie	dc. County of D	-
Funeral Director	5. Social Security Number 220−58−9402 6. Sex 7. Age (In yrs. last birthday 1 □ M 2 1 F 52 Yrs.) If Under 1 Year If Under 24 Hrs. Months Days Hours Min.		Birthplace (State or Foreign County) ary Land
rland f show d at	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or I	ocation		10d. Inside City Limits
items 23a or 28a-f shoer must be notified at	MD Prince Georges Bowie	10f. Zip Code	10g. Citizen of What United Sta	1 X Yes 2 □ No Country?
must b	14634 London Lane	20715		
JU36 Jrs after dea ural", or ite	1 Never Married 2 X Married 1 Yes 2 X No	. Was Decedent of Hispanic Origin? (Spe If Yes, specify Cuban, Mexican, Puerto 1 ☐ Yes 2 ☑ No Specify:	Rican, etc.) 14. Race - A Black, W Specify: W	
Aaryland 21215-0036 should be filed within 72 hours after death with the Maryland and Mental Hygiene. Is marked other than "natural", or items 23a or 28a-f show raumatic event, the Medical Examiner must be notified at	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Info	edent's Usual Occupation e kind of work done during most of work DO NOT use retired rmation "Operator:	ng 16b. Kind of Busine Telecommun	· ·
Maryland 2 2 should be filed w th and Mental Hyg 27 is marked othe traumatic event,			n Krowitz	
□ = 2 =	19a. Informant's Name/Relationship (Type, Print) Boyd Eugene Thompson-Husband 1463	iling Address (Street and Number or Rure 4 London Lane Bow	l Route Number, City or Town, State, ie, MD 20715	Zip Code)
nore, ige 1 and of Hei ti If item 7 or othe	20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 20b. Place of Discemetery, cr	position (Name of ematory or other place) rid Mem Grdns 03/0	20c. Location - City	or Town, State urch, Virginia
Saltimore , permit. Page 1 and Department of Hea Important: If item any injury or other once.	4 ☐ Donation 5 ☐ Other (Specify) King Dav 21. Signature of Funeral Service Licenses Mol1163	22. Name and Address of Facility dwa Inc. Rockville, M		
n vores	23a. Part 1. Enter the disease, or complications that caused the death. Do not el			Approximate
Physician/ Medical	shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Cardiac Arrythm Due to (or as a consequence of):	ia		Interval Between Onset and Death
Examiner	Diabetes			
orthod Carlo	if any, leading to immediate Cause Enter Underlying Cause (Disease or injury that initiated events C.			
te be executed hysician and the burial fails and th	resulting in death) Last Due to (or as a consequence of): d.		/	
death certificathe attending placed for use as the distribution.	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☒ Unknown 23c. If yes, outcome of pregnancy 1 ☐ Live Birth 2 ☐ Fetal death 3 4 ☐ Pregnant at time of death 5	Ectopic pregnancy Other (specify)	23d. Date of Month	delivery Day Year
uires that the n signed by the detacl	Fair ii. Other significant conditions contributing to death but not resulting in the		23e. Did tobacco use contribute 1 Yes 2 X No 3	e to the cause of death? Probably 4 Unknown
VITAI MECORDS, vsician: The law requires is certificate has been sig director, page 2 should	Obstructive Sleep Disorder		autopsy prior performed? deatl	e autopsy findings available to completion of cause of h? Yes 2 🏻 No
ician: certor, ector,	25. Was case referred to medical examiner?	26. Place of Death (Check		
ding Physi ding Physi h. After this o funeral din	1 Inpatient 2 ER/Outpat	ient 3 LI DOA 4 LI Nursing Ho of 28c. Injury at	me 5 🔀 Residence 6 🗆 Other (S) 28d. Describe how injury occurred	pecify)
DIVISION OF Tal or Attending PI s after death. In Director: After the ed in by the funera	2 Accident Investigation 3 Suicide 6 Could not be 4 Homicide 28e. Place of Injury - At home, farm, s building, etc. (Specify)		28f. Location (Street and Number or City or Town, State)	Rural Route Number,
To the Hospital or Attending Physician: The la within 24 hours after death. To the Funeral Director: After this certificate ha Completely filled in by the funeral director, page	29a. Certifier 1 X Certifying Physician: To the best of my knowledge, deat (Check 2 Medical Examiner: On the basis of examination and/or inv only one) 3 Certifying Nurse Practitioner: To the best of my knowled	estigation, in my opinion, death occurred a	the time, date and place, and due to t	the cause(s) and manner stated.
Port Port	29b. Signature and title of certifier	29c. License number D64690	29d. Date signed (Me February	
	30. Name and address of person who completed cause of death (Item 23a) (Type Eveline Ane, MD 7219 Hanover Parks	, Print) way, Suite B Green	nbelt, MD 20770	
State Registrar	31. Date filed (Month, Day, Year) NAR 0 2 2012 31. Registrar's Signature	wes.		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ March 16 30 PM FRANK ALLAN THOMAS 2012 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Talbot Hospita aston emoria 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs 6. Sex 1 **X** M 2 □ F 8. Date of Birth 9. Birthplace (State or Foreign Funeral Months Days Hours AUG - 9 - 1944 MARYLAND 67 Director 216-42-1001 Usual Residence of Decedent show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits at Director notified 28a-f 1 Yes 2 X No MD CAROLINE DENTON 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? ö "natural", or items 23a or edical Examiner must be Funeral 22426 SHORE HIGHWAY 21629 USA 12. Was Decedent Ever in U.S. 11 Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14 Bace - American Indian Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Never Married 2 Married δ 72 hours after Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates Specify: Completed 3 Widowed 4 Divorced WHITE event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry is marked other than College (1-4 or 5+) Elementary/Seconday (0-12) FOOD SALESMAN Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည MARGARET VIRGINIA DEALE FRANK WILLIAM THOMAS 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau 22426 SHORE HIGHWAY, DENTON, MD 21629 C. ELLEN THOMAS/WIFE 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State CHESAPEAKE CREMATION STEVENSVILLE, MD 4 ☐ Donation 5 ☐ Other (Specify) 3/6/2012 CENTER 22. Name and Address of Facility
FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME, P.A. . Signature of Funeral Service Licens 408 S. LIBERTY ST., CENTREVILLE, MD 21617 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, Examine if a 1y, leading to immedicause. Enter Underlying Due to for as a consequence of requires that the death certificate be executed Cause (Disease or linjury that initiated events resulting in death) Last burial-trar Due to (or as a consequence of): the attending physician Physician/Medical P.O. Box 68760 the use as 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No ģ Day 5 Other (specify) Month Year Pregnant at time of death hed f 9 Unknown signed by t. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ρ Records, 1 Yes 2 No 3 Probably 4 Unknown Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe Yes 2 has certificate 1 Yes 2 No 25. Was case referred to medical examiner?

1 Yes 2 No **Division of Vital** Hospital or Attending Physician; funeral director. 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: မ 1. Inpatient 2 ER/Outpatient 3 DOA After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work?
1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred 1 Natural injury 5 Pending Accident Investigation 24 hours after death Funeral Director: completed filled in by the 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 To the F only one) 29b. Signature and title of cen 29c. License number 29d. Date signed (Month. Dav. Year) 2 £\$65656 Name and address of person who completed cause of death (Item 23a) (Type, Print) 32 Registrar's Signature State 2012 5 Registrar

03

d

920

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

William Tr	rent	amend #15;	ate of Mary		artment of artificate of		and M	fental F		2	012	085
Physicia	an/	Registrar 1. Decedent's Name (First, Middle)	le,Last)			-			2. Date of Dea	keg. No.		e of Death
al Exami		MORAL WILLIA 4a. Facility Name (if not institution		ımher)		b. City, Town	or Loca	tion of Dog	Month February	Day Year 29, 2012	19	00 hrs
		800 Church Hill Road	ii, give sileet alid iii	uniber)		Centrevil		uiorror Dea	uı	Queen A		
Funeral Director		5. Social Security Number 129–18–3208	6. Sex	7. Age (In yrs. 84		If Under 1 \ Months D		Under 24H Hours Mi		irth(MM/DD/YYYY)	9. Birthplace ForeiWASH	(State or INGTON,
57		Usual Residence of Decedent	121 M 2 F		Yrs.				09/03	71927		
nd show any		10a. State 10b. County	ANDIDAC	10c. City	, Town or Location							nside City Limits Yes 2 No
Sa-f sh	Director	MD QUEEN 10e. Street and Number	N ANNE'S		CENTREV	10f. Zip Cod	9			10g. Citizen of Wh		103 2110
uld be filed within 72 hours after death with the Maryland Mental Hygiene. marked other than "natural", or items 23a or 28a-f she c event, the Medical Examiner must be notified at once		800 CHURCH HI				21	617			USA		
items items	Funeral	11. Marital Status 1 Never Married 2 X Ma	arried Armed F			Decedent of es, specify Cul			Specify Yes or No o Rican, etc.)	0- 14. Race - White		ian, Black,
ral", or	by Fu		orced If Yes, Give Yes or Dates:			Yes 2				Specify:	Black WHITE	
2 hours		 Decedent's Education (Specific Elementary/Secondary (0-12) 	cify only highest gra		16a. Decedent during mo	's Usual Occu ost of working				16b. Kind of Bus	iness/Industry	
led within 7. Hygiene. other than the Medical	Completed	12	-0-		CONSTRU	CTION	SUPE	RINTE	NDENT	CONS	TRUCTIO	N
uld be filed withi Mental Hygiene. marked other ti	Be Co	17. Father's Name (First, Middle, WILLIAM TREN)	•							Maiden Surname)		
0 77 88 4	7 E	19a. Informant's Name/Relationsh			7.1		reet and	Number or		mber, City or Town		
and 2 sho ealth and tem 27 is tranmativ		LOREEN I. TRENT 20a. Method of Disposition	r/ WIFE	20b.	800 C				Date Date	EVILLE,]		
Pages I and 2 shou ment of Health and I tant: If item 27 is n or other tranmatic		1 Burial 2 X Cremation		om State CH	ESAPEARE NTER				CH 2,	STEVENS		
permit. Pages 1 and 2 sh Department of Health and Important: If item 27 is injury or other tranmat		4 Denation 5 Other So 21 Igniture of Fineral Service		/ ICE		ame and Addr	ess of Fa			AM FUNER	AT. HOME	P.A.
ysician	0	23a. Part I. Enter the disease, or	complications that c	aused the death	1408	S. LI	BERT	Y ST.	, CENTR	EVILLE, I	MD 2161	zximate Interval
Medical caminer		failure. List only one cause Immediate Cause (Final disease					·			,		een Onset and Death
anner		or condition resulting in death)	Due to (or as a	consequence o	of):				•••			
	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause	Due to (or as a	consequence o	of):				-			
sit sit	Examine	(Disease or injury that initiated events resulting in death) Last	Due to (or as a	consequence o	of):						-11-	
be executed sician and urial - transit	dical	UNPENDED	dAMENDED									
	w	IF FEMALE: 23b, Was decedent pregnant in the		outcome of preg	nancy			-		23d. Date of d	elivery	_
h ce tend use	Physician/M	past 12 months?	4 Pregn	irth ant at time of de	ath	al death (Specify)	BEct	topic pregn	ancy	Month	Day	Year
v ± 5	Phys	1 Yes 2 No 9 Unk	9 Unkno		esulting in the un	deriving caus	a diven ir	n Part I	23e Did to	bacco use contrib	ute to the caus	e of death?
(O 50 d)	全					- In the second				s 2 √ No 3		
w requi	Completed								24a. Was autop	sy pri	ere autopsy fin or to completic	dings available on of cause of
ysteran: The lar his certificate ha director, page 2	8	W							1 Yes	med? de 2 ✓ No 1 [ath? Yes	2 No
ricenti iis certi director	o Be	25. Was case referred to medical examiner? 1 ✓ Yes 2 No	Hospital: 1	npatient 2	ER/Outpatient		Other	ath (Check		Residence 6 ✓	Other: Scene	
After th	۲	27. Manner of Death	28a. Date FOUND	of Injury Day,Year)	28b. Time of Inj	· _	jury at W	_	28d. Describe t	now injury occurred	1	
Attend r death rector: by the	Certification:	2 Accident Invest	rigation Feb 29,	2012	1840 hrs ome, farm, street,		Yes 2			Street and Number	or Rural Route	Number City
ours afte		3 ✓ Suicide 6 Could 4 Homicide determ	not be	Single Fan		, radiory, office	Danang	g, Oto.	or Town, S			e Number, City
	edical C		ysician: To the bes									(2
with Total comp	Medi	29b. Signature and title of certifier	and manner st			29c. Lice	_			29d. Date signed		
		Caled	11	14	DL	0.0	M.E.			March 1, 20		
chity		30. Name and address of person v Zabiullah Ali, M.D. A	who completed caus			altimore Str	eet R	altimore	MD 21223			
Sta	ate	31. Date filed (Month May Leaf)		gister's Signatu	-	arks						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ FLORA MAE THOMPSON FEBRUARY 26. 2012 Medical 3:34 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 128 MONTAGUE LANE ELKTON CECIL Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** 1 🗆 M 2 🔀 F Days MAY 26, 1927 Months Hours 424-30-9314 84 Director Yrs. **ALABAMA** Usual Residence of Decedent 28a-f shov 10a. State with the Maryland notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MARYLAND CECIL NORTH EAST 1 Tes 2 X No 10e. Street and Number r items 23a or ner must be n ò 10f. Zip Code 10g, Citizen of What Country? Funeral 1730 W. OLD PHILADELPHIA ROAD 21901 UNITED STATES permit. Page 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items any injury or other traumatic event, the Medical Examiner muone. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian Black, White, etc. ò 1 Never Married 2 Married 1 Yes 2X No If Yes, Give Year or Dates. Baltimore, Maryland 21215-0036 1 ☐ Yes 2X☐ No Specify: Completed 3 X Widowed 4 Divorced Specify: BLACK 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) NUTRITION SERVICE SUPERVISOR VA HOSPTIAL Be 17. Father's Name (First, Middle, Last, 18. Mother's Name (First, Middle, Maiden Surname) ည DEMPSEY YELDER MATTIE MAY BRUNER 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) DIANE L. THOMPSON / DAUGHTER 1730 W. OLD PHILADELPHIA RD, NORTH EAST, MD 21901 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State CARMEL CEMETERY MT. 4 ☐ Donation 5 ☐ Other (Specify) 3/3/12 NORTH EAST, MARYLAND 22. Name and Address of Facility LISA SCOTT FUNERAL HOME, P.A. 21. Signature of Funeral Service Licensee 552 LEWIS STREET, HAVRE DE GRACE, MD 21078 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause _n_ ach line. Immediate Cause (Final The name Ons t and Death Physician/ Cancer disease or condition , Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or ilnjury Due to (or as a consequence of): executed physician and s the burial-trans that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical The law requires that the death certificate be attending pl IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? 1 Yes 2 No Day Year Pregnant at time of death detached g Unknown Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy 1 Yes 2 No 1 Yes 2 No 25. Was case referred to medica Be 26. Place of Death (Check only one) 1 Yes 2 No Other: မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending injury work? 1 🔲 Yes 2 🖵 No Accident Investigation Suicide Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, Homicide City or Town, State)

Division of Vital Records, P.O. Box 68760 after death.

Director: After this certificate To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Disperse completed filled in by the funeral director,

► Sciencler SND	D0023322	2.28.2012
30. Name and address of person who completed cause of death (Item 23a) (Type, Prin 5 . S SACHDEV MD . 126 A, E His	ST, Elisa MD 21	i921.
31 Date filed (Month Day Year)		

Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29c. License number

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29d. Date signed (Month. Day, Year)

State Registrar

Medical

29a Certifier

(Check

only one)

29b. Signature and title of certifier

10

2 2012 Jane A. park

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ March $20\overset{\text{Year}}{12}$ Bertha Edna Thompson 2000 Рм Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Calvert Manor Healthcare Center Rising Sun Ceci1 Social Security Number If Under 1 Year If Under 24 Hrs. **Funeral** Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign 1 🗆 M 2 💢 F Months Davs JAN 24, Year 915 New Jersey 97 Director 222-18-2011 Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a, State 10b. County ral", or items 23a or 28a-f sho Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 🛱 Yes 2 □ No New Castle Delaware Middletown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 55 North Cummings Drive 19709 United States 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☒ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White "natural" Completed Year or Dates permit. Page 1 and 2 should be filed within 72 hour Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natu any injury or other traumatic event, the Medical 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Clerk Typist Chemical Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မှ George E. Hughes Anna B. Meghan 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Barbara A. Minshull/Daughter North Cummings Drive, Middletown, DE20a, Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State March 6. 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State 4 Donation 5 Other (Specify) Gracelawn Memorial Park 2012 New Castle, DE 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Hicks Home for Funerals, P.A. 103 W. Stockton Street, Elkton, MD 21921 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) attending physician and for use as the burial-transi Cause (Disease or lingury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d Date of delivery 3 Ectopic pregna 5 Other (specify) in the past 12 months?
1 \(\sum \) Yes 2 \(\sum \) No Live Birth 2 Line of death
Pregnant at time of death
Unknown page 2 should be detached for Day 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ To the Hospital or Attending Physician: The law requires 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy within 24 hours after death.

To the Funeral Director: After this certificate 2 No Yes 1 Yes funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: 1 Tyes 2 X No Other ည 1 Inpatient 2 ER/Outpatient 3 DOA 4 XNursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural Accident injury work? 5 Pending 2 No Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide 28f, Location (Street and Number or Rural Route Number, determined City or Town, State Medical 29a. Certifier 1 🚅 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of ce 29c. License numbe

State Registrar DHMH 17 Rev 7/2009 rous

740M

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

			_ State	State of Maryla		artment of F <i>tificate of L</i>			- U	2 08551
-		3	Registrar Decedent's Name (First, Middle, Last)		Cer	uncate or L)ealii	2. Date of Dea	Reg. No.	3. Time of Death
	Physicia Medic		Lena N. Tringali					MARCH	Day Yea	
100	Examir		4a. Facility Name (if not institution, give stre	,	0.	4b. City, Town, or			4c. County of D	
-	Francis		5. Social Security Number 6. Sex	HOSPITA	s. last birthday)	BAL If Under 1 Year	If Under 24		Noi	ne Birthplace (State or Foreign
k	Funeral Director		, and the second	w 2 🔀 F 81		Months Days		Min. (Month, Da	y, Year)	Country) MD
	d to d	_	Usual Residence of Decedent 10a, State 10b, County	100	City, Town or Loc	ention		06/11/1	.930	10d. Inside City Limits
	larylan ka-fsh ified a	Director	MD Howard		Colu					1 🗆 Yes 2 🖰 No
	the M or 28 oe not	- Dir	10e. Street and Number			10f. Zip Code			10g. Citizen of What	Country?
	h with ns 23e nust k	Funeral	5114 Durham Road E	last			1044		United	States
10	72 hours after death with the Maryland n "natural", or items 23a or 28a-f show Aedical Examiner must be notified at	by Fu	11. Marital Status 1 X Never Married 2 Married	. Was Decedent Ever in I Armed Forces? 1 ☐ Yes 2 🎛 No	U.S. 13. V	Vas Decedent of Hi Yes, specify Cuba	spanic Origin n, Mexican, F	? (Specify Yes or No- Puerto Rican, etc.)	14. Race - A Black, W	merican Indian, hite, etc.
036	rs afte ural", (Exan		3 Widowed 4 Divorced	If Yes, Give Year or Dates.	1	☐ Yes 2X No	Specify:		Specify:	White
15-0	2 hou "natu edical	plet	15. Decedent's Educa (Specify only highest grade	ation completed)	(Give k	ent's Usual Occupa	ation Juring most of	f working	16b. Kind of Busine	ss/Industry
121	thin ane. tha	Completed	Elementary/Secondary (0-12)	College (1-4 or 5+)		NOT use retired) ccountan	t.		Accou	nting
d 2	it it de	Be	17. Father's Name (First, Middle, Last)		~		18. Mother's	s Name (First, Middle,	Maiden Surname)	
ylar	should be file n and Mental I 7 is marked o raumatic eve	욘	Philip Tringali				C	armella Ma	rsiglia	
Maryland 21215-0036	2 should be th and Men 27 is marke traumatic		19a. Informant's Name/Relationship (Type, Carmella M. Darmste		221	•		or Rural Route Numbe		
	and Health		20a. Method of Disposition		D. Place of Dispos	sition (Name of	1	ad Ellicot	20c. Location - City	
moi			1 Surial 2 ☐ Cremation 3 ☐ Re	moval from State	cemetery, crem rest Law	atory or other plac		/08/2012	,	tsville, MD
Baltimore,	permit. Page Department of Important: If any injury or once.		21. Signatury of Furreral Servic-Lichnsee	4						amily FH Inc.
<u>m</u>	90 E 29		more ym	iailo	41	12 Old C	olumbi	<u>a Pike Ell</u>	icott City	y, MD 21043
	an a service		23a. Part 1. Enter the disease, or complica shock, or heart failure. List only one of Immediate Cause (Final	auce on each line		,			rest,	Approximate Interval Between Onset and Death
,M	Physician/ Medical		disease or condition resulting in death)	ACENITO Due to (or as a conse	BACT	GR Y	NEUN	LUNIA		5 DAYS
	Examiner			KLEBSIE	LLA	UTI				5 DAYS
	7 4	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a conse	equence of):		101	(D) 2 2 3		
	ecute and I-trans	Examiner	Cause (Disease or injury that initiated events c. resulting in death) Last	Due to (or as a conse		restin	VAL	BLEEJ)	UNKNOWN
0	cate be executed physician and s the burial-transit	edical	L							
8760	ificate ng phy as the		IF FEMALE:							
.89 x	eath cerrifica attending pl	Physician/M	23b. Was decedent pregnant in the past 12 months?	If yes, outcome of preg	etal death 3		у		23d. Date of Month	delivery Day Year
Box	re dea / the a ched f	ysic	1 Yes 2 No 9 Unknown	4 ☐ Pregnant at time of 9 ☐ Unknown	of death 5 L	Other (specify)			Mona	Day Teal
Division of Vital Records, P.O.	requires that the death cert been signed by the attending should be detached for use	by Pi	Part II. Other significant conditions contri	-	-		en in Part I.	23e. Did to	obacco use contribute	to the cause of death?
ds,	quires en sig ould b	ted	ACUTE REN	AL FAT	LURE,			1 🗆 '	Yes 2 □ No 3 □	Probably 4 D Onknown
COL	law re has be ge 2 sh	Completed	RECENT PUL	SELESS	ELECT	RICAL	ACTI		osy prior	autopsy findings available completion of cause of
l Re	n: The ficate or, pag		CARDIAC AR 25. Was case referred to medical	REST.				1 🗆 Yes	rmed? death	Yes 2 No
Vita	ysicial s certi directo	To Be	examiner?	pital:	☐ ER/Outnation	Othe	er.	(Check only one) ing Home 5 □ Resid	Yanca 6 □ Other (Sc	aciful
of	ng Phy ter thi ineral		27. Manner of Death 1 Matural 5 ☐ Pending	28a. Date of injury (Month, Day, Year)	28b. Time of injury	28c. Injury work	at		ow injury occurred	ecny
ion	tendir Jeath. tor: Af the fu	Certificate:	2 Accident Investigation			M 1 🗆	Yes 2 No			
ivis	l or At after o Direct I in by	Cerl	4 Homicide determined	28e. Place of Injury - At building, etc. (Spec		et, factory, office		28f. Location (S City or Tow	Street and Number or i n, State)	Ru <i>ral Route Number</i> ,
	To the Hospital or Attending Physician: The law requires that the death certific within 24 hours affer death. To the Funeral Director. After this certificate has been signed by the aftending completely filled in by the funeral director, page 2 should be detached for use as	Medical	29a. Certifier 1 Certifying Physicia	n: To the best of my kno	owledge, death o	ccurred at the time	, date and pla	ace, and due to the ca	ause(s) and manner as	stated.
	the H hin 24 the Ft	Mec	only one) 3 Certifying Nurse P			death occurred at the	ne time, date a	and place, and due to t	he cause(s) and manne	
	To voit		29b. Signature and title of certifier)		29c. License	number 144		29d. Date signed (Mo	nth, Day, Year) -12012
	K		30. Name and address of person who comp	oleted cause of death (Ite	em 23a) (Type. Pi		-14	00	03/09	7 20 12
	10		SINDHUJA MAR	UPUDI,			VENU	G, BALTI.	MORE, M	D 21229.
	Stat		31. Date filed (Month Park eac) 5 201	2 32. Registrar's Sign	nature &	arke				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Physician/ February 2012 Audrey Dill Umpleby 7:42P Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death 822 Midship Court Annapolis Anne Arundel If Under 1 Year | If Under 24 Hrs. Social Security Number 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** Days Hours 1 🗆 M 2 💢 F 1171271927 90 Mary Tand Director 710-09-6114 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director must be notified Marvland Anne Arundel Annapolis 1 Yes 2X No 10e. Street and Number 10f. Zip Code ō 10g. Citizen of What Country? Completed by Funeral 23a 822 Midship Court 21401 USA ral", or items ? 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian Armed Forces?
1 ☐ Yes 2 🗓 No Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give White 3 🕅 Widowed 4 🗆 Divorced Year or Dates. traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Electronics Executive Secretary Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Norman Merritt Dill Maude Strube ge 1 and 2 should b nt of Health and Mer :: If item 27 is mark 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Carol A. Dunlap/ Daughter 4010 Broomes Island Rd., Port Republic, MD 20676 other t 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Department of Important: If it any injury or o 1 M Burial 2 Cremation 3 Removal from State Woodlawn Cemetery 3/5/12 Baltimore, MD 4 ☐ Donation 5 ☐ Other (Specify) Signature 22. Name and Address of Facility George P. Kalas Funeral Home 2973 Solomons Island Rd. Edgewater, MD 21037 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ Knotwee d ancus Vin disease or condition resulting in death) Montk Medical Due (or as a consequence of) **Examiner** Inusted 4 ion Sequentially list conditions Examine if an , leading to immediate cause. Enter Underlying Distriction (or as a consequence of) burial-transit Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): attending physician I for use as the buria Physician/Medical Box 68760 IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 Fetal death 3 Ectopic pregnancy
5 Other (specify) ned by the atter detached for u in the past 12 months? 1 ☐ Yes 2 ☑ No Day Month 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available has prior to completion of cause of death? autopsy performed? Yes 2 X No 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: 2 X No Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 X Residence 6 Other (Specify) this e Hospital or Attending Ph 124 hours after death, e Funeral Director; After th 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation
6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 24 hours Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

DHMH 17 Rev 7/2009

State Registrar only one)

ANGELL

29b. Signature and title of certifier

CALLE,

31. Date filed (Month, Day, Year) 1 2012

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

129

nu

LKRYRLHO

32. Registrar's Signature

29c. License number

DRIVE GRITE IW,

DA1479

29d. Date signed (Month, Day, Year)

ANHAPOLIS

2012

21401

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ February 24, 2012 **7:48 р** м Twanna M. Wilkerson Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Calvert Huntingtown 1340 Avery Road If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** 1 □ M 2 🔀 F Hours Min June 23, Country) 1956 Yrs **Director** 55 220-66-8704 Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits traumatic event, the Medical Examiner must be notified at Director 1 Yes 2 No MD Calvert Huntingtown P 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a Funeral USA 1340 Avery Road 20639 "natural", or items within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian 11 Marital Status Black, White, etc. þ 1 Never Married 2 Married Yes 2 No Yes, Give Baltimore, Maryland 21215-0036 1 Yes 2 No Specify. Specify 3 Widowed 4 Divorced Completed Black Year or Dates 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Housekeeper Hospital Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be file Department of Health and Mental I Important: If item 27 is marked o any injury or other traumatic eve ဂ္ Gladys Eleanor Hicks William Robert Wilkerson, Sr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2165 Oliver Drive Prince Frederick, MD 20678 Shaiwian Mackall - daughter 20a, Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State 1 🔀 Burial 2 🗌 Cremation 3 🔲 Removal from State Young's Church Cemetery | March 2, 2012 | Huntingtown, MD 4 Donation 5 Other (Specify) Signature of Funeral Service Licensee 22. Name and Address of Facility Sewell Funeral Home, P.A. Blad 1451 Dares Beach Rd. Prince Frederick, MD 20678 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line. Immediate Cause (Final Phylician disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): The law requires that the death certificate be executed Cause (Disease or linjury that initiated events resulting in death) Last and-trar Due to (or as a consequence of): attending physician a for use as the burlal-Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 months? Day Pregnant at time of death the g 🗌 Unknown P.0. by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No has this certificate 1 Yes 2 No Hospital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: ဂ္ဂ ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify, 1 Inpatient 2 eral Director: After thi filled in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural 5 Pending work? 2 🗌 No 1 Yes ☐ Accident☐ Suicide Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined hours after within 24 hours a

To the Funeral I

completed filled Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29c. License number

doew State

Mahin 31. Date filed (Month, Day, Ye 32. Registra s Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

tazdanı

Market.

D0017774

02-27-2012

Huntingtown MD 20639

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Year **Physician** 2012 YC varne Marc /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Talbot Manor lliam Ton If Under 24 Hrs. Birthplace (State or Foreign Country) Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, **Funeral** Months Days Hours 214-32-5791 Usual Residence of Decedent 1 1 M 2 □ F Marylano Director 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State ral", or iteπs 23a or 28a-f sho Ex∗miner must be notifled at 1 Des 2 No Talbot Easton by Funeral Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code faileM School USH Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. and 2 should be filed within 72 hours after lealth and Mental Hygiene. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 □Yes 2 **I**No Specify. Black 3 ₩Widowed 4 □ Divorced "natural" Be Completed other traumatic event, If e Wedical 16a Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) nd Mental Hygiene. marked other than Elementary/Secondary (0-12) College (1-4or 5+) andscapeContractor 17. Father's Name (First, Middle, Last) Mother's Name (First, Middle, Maiden Surname) Warner ၀ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Road-20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 DBurial 2 ☐ Cremation 3 ☐ Removal from State Maryland Easton 4 ☐ Donation 5 ☐ Other (Specify) Cemet 22. Name and Address of Facility Home, P.A. Henry Funeral Home, P.A. Sic Washington St. Cambr. 21. Signature of Funeral Service Licensee 23a. Par 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) END-STAGE CHRONIL KIONEY **Physician** /Medical Examiner CARDIOVASCULAR ATHEROSCLEROTIC Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner burial-transit The law requires that the death certificate be executed Due to (or as a consequence of) Box 68760, Physician/Medical IF FEMALE: for use 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year in the past 12 months? Month Day 4 ☐ Pregnant at time of death 5 Other (specify) ☐Yes 2 ☐No o 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Be Completed by CARDIO MYOPATHY, MULTIPLE 3 Probably 4 Unknown 1 ☐ Yes 2 No MYELOMA, COROLARY ARTERY DISEASE 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? Yes 2 No 1 □ Yes Division of Vital To the Hospital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Medical Certification: To 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No 24 hours after death. Funeral Director: A investigation 2 Accident 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death accurred. 29a. Certifier within 24 hounded the total tile to the Funer completely file (Check only one) Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature an D0053094 ATTENDING MD and address of person who completed cause of death (Item 23a) (Type, Print) ALL M VEINBOLDIND 32113 100 MWGDAL 31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001

State

Registrar

MAR 06 2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene
State Amend Item 25 per me,g925,03/29/2012dhb
Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ PERRUARY Day 2017 Evelyn D. Williams Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Deat BACTIMORE WASHINGTON MESILAL C BURNIE Anne If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Funeral 1 🗆 M 2 🔀 F Hours (Month, Day, Ye. Country 033-24-5707 Director 78 Usual Residence of Decedent 28a-f show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "--- any injury or other than "---10c. City, Town or Location 10d. Inside City Limits Director MD Anne Arundel Severna Park 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21146 715 Benfield Road USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 2 No
If Yes, Give Black, White, etc þ 1 Never Married 2 Married White 1 ☐ Yes 2 X No Specify: Specify Completed 3 Widowed 4 X Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Community College 5+ Advisor Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Evelyn Costello Joseph Sousa 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) John Williams/Son 10 Woodbent Drive Severna Park, MD 21146 KILLIA MC 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 2012 Hillcrest Mem. Gardens Annapolis, MD 4 Donation 5 Other (Specify) Signature of Funeral Service License Barranco & Sons, P.A. Severna Park Funeral Home 495 Ritchie Hwy. Severna Park, MD 21146 233 | art 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or reart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Conse (Final disease or condition resulting in death) INTRACERE BRAL Physician/ HEMORZHACE Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or impury Examiner Due to (or as a consequence of) use as the burial-transi that initiated events resulting in death) Last Due to (or as a consequence of) tor. Ifter this certificate has been signed by the attending physician the funeral director, page 2 should be detached for use as the burial Physician/Medical death certificate be Box 68760 IF FEMALE: yes, outcome of pregnancy

☐ Live Birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy
☐ Pregnant at time of death 5 ☐ Other (specify) ____ 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year 9 Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by the Hospital or Attending Physician: The law requires Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🗹 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed Yes 2 1 Yes 2 No Vital 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) Sion of V Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending injury 1 Yes 2 No Accident Investigation М within 24 hours after deat To the Funeral Director. Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide completed filled in by determined Medical 29a. Certifier 🗹 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated only one) Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature cause of death (Item 23a) (Type, Print) Gleu Burnie MS 20161 lave 31. Date filed (Month, Day, Y

DHMH 17 Rev 7/2009

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Physician Month Mildred Gwendolyn Wray 2040 21, 2012 February /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** Atria Assisted Living Salisbury Wicomico If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Months Davs Hours 1 □ M 2 🕱 F 213-60-2194 Director 95 Sep. 20, 1916 Maryland Usual Residence of Decedent 10a, State 10c, City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No Wicomico Salisbury 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1110 Healthway Drive by Funeral 21804 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 □Yes 2 🖾 No Specify: White 3 XWidowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Homemaker Home 17. Father's Name (First, Middle, Last) Be 18. Mother's Name (First, Middle, Maiden Surname) Archibald A. Pfeiffer Mildred Hall ည 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Cheryl Kirk/Daughter 113 Seafarer Lane Berlin, MD 21811 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 27, 20c. Location - City or Town, State permit. Pages 1 Department of H Important: If Itel any injury or ott once. 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Loudon Park Cem. Baltimore, MD 4 Donation 5 Dother (Specify) 21. Signature of Juneral Service Uic r see Barranco & Sons, P.A. 495 Ritchie Hwy. Severna Park Funeral Home Severna Park, MD 21146 23a. P rt1. Enter the disease, or domplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ock, or eart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Afurwideloute CAUDIOURSCHIAU LISCAR Physician isease or condition esulting in death) /Medical Due to (or as a consequence of): Examiner Fallyve Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to for as a consequence un Due to (or as a consequence of). Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 5 Other (specify). ☐Yes 2☐No 9 Unknown 9 Unknown Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 2000 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 2 Accident 1 □Yes 2 □ No 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide

The law requires that the death certificate be executed P.O. Box 68760, attending p signed by the a d be detached for of Vital Records, To the Hospital or Attending Physician: The within 24 hours after death.

To the Funeral Director: After this certificate I completely filled in by the funeral director, page Division

1 and 2 should be filed within 72 hours after death with the Maryland Health and Mental Hygiene.

em 27 is marked other than "natural", or items 23a or 28a-f show ther traumatic event, the Medical Examination and the traumatic event, the Medical Examination.

item 27

physician and s the burial-trans

altimore, Maryland 21215-0036

Medical Registrar

alongly enp 106

Woule

MILLERY SI SOUR SALIShury MAD ZISOU

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year)

29a. Certifier

(Check only one)

29b. Signature and title of certifier

Mallelly

32. Registrar's Signature

1 Gertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

29d. Date signed (Month, Day, Year)

State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Februar Year L. 11:20 AM Walter Wichita Medical 4a. Facility Name (if not Institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Severna Park Anne Arundel Sunrise Assisted Living Social Security Number If Under 1 Year If Under 24 Hrs. Funeral 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 6. Sex 7. Age (In vrs. last birthday) 1 🔀 M 2 🗆 F 90 507-14-7827 Director Nebraska 31,1921 Usual Residence of Decedent 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD Anne Arundel Arnold 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1020 Smith Drive 21012 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1949-1 X Yes 2 No 1974 11. Marital Status 14. Race - American Indian, Black, White, etc Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: White 3 XWidowed 4 □ Divorced Specify: Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Engineering Value Engineer Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Mary Riha Arnold Wichita ge 1 and 2 should be nt of Health and Mer : If item 27 is marke 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
38 Dulaney Hills Court Cockeysville, MD 21030 38 Dulaney Hills Court Kathleen Noppinger / Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Feb. 28, permit. Page 1 Department of Important: If it X Burial 2 Cremation 3 Removal from State MD Veterans Cemetery Crownsville, MD 4 Donation 5 Other (Specify) 2012 Signature of Funeral Service Licensee 22. Name and Address of Facility Barranco & Sons, P.A. Severna Park Funeral Home Severna Park, MD 21146 495 Ritchie Hwy, 23a. Part 0. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or reart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ disease or condition Medical resulting in death) **Examiner** Sequentially list conditions, Examine Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Cause (Disease or injury attending physician and for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ____ 1 Live Birth 2 Fetal death 4 Pregnant at time of death in the past 12 months? Month Day Year signed by the al d be detached fo 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 2 No 3 Probably 4 Unknown 1 Yes this certificate has been siral director, page 2 should? 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 Yes 2 No 25. Was case referred to medical Division of Vital funeral director, 26. Place of Death (Check only one) Be examiner? ASSISI UNITISC Other: 4 Nursing Home 5 Residence 6 Other (Specify) မ 1 Tyes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred To the Funeral Director: After completed filled in by the funer 1 Natural 5 Pending 1 Yes 2 No Accident Suicide Investigation Could not be 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State, 24 hours Medical 29a. Certifier 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Signature and title of certifier 29c. License number 57531 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 8601 Veterans Millersur 31. Date filed (Month, Day, Year) FEB 2 9 State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 2 8 Physician/ Month Ilse S. Westphal 6: 56AM -cbruary 2012 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Heart Home @ Bay Ridge Anne Arundel Annapolis 8. Date of Birth (Month, Day, Year) Feb. 20, 1920 If Under 1 Year If Under 24 Hrs. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Germany Days 403-84-9700 Director 1 M 2XXX 92 Usual Residence of Decede 28a-f shov 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ms 23a or 28a-f sho must be notified at **Funeral Director** Anne Arundel Annapolis Maryland 1 Yes 2 X No 10g. Citizen of What Country? U.S.A. 10f. Zip Code 3354 Harness Creek Road 21403 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Examiner Armed Forces Black, White, etc. o ģ Yes 2 X No Yes, Give 1 Never Married 2 Married nan "natural", Medical Exan White 1 ☐ Yes 2 🔀 No Specify: Completed Specify: 3XXWidowed 4 ☐ Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry المالية. عالم Hygiene. معادلتات من مالية. (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) the Homemaker Own Home 12 should be filed with and Mental Hygien 7 is marked other the Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Friedrich Schlegelmilch Louisa Hubois 19a. Informant's Name/Relationship (Type, Print) Department of Health an Important: If item 27 is 1 any injury or other traumone. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Annette Finnegan/daughter 3354 Harness Creek Road Annapolis, Maryland 21403 20a, Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1

Burial 2

Cremation 3

Removal from State Baltimore Crematory 3/2/2012 Baltimore, Maryland 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility John M. Taylor Funeral Home 01 147 Duke of Gloucester St., Annapolis, MD 21401 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Je mentra Medical Due to (or as a consequence of). Examiner Sequentially list conditions, if a year of the cause. Enter Underlying Cause (Disease or injury that initiated events Due to for each generousing offiand resulting in death) Last Due to (or as a consequence of): physician a the burial-Physician/Medical IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No Day Year signed by the a ld be detached f 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown Were autopsy findings available prior to completion of cause of death? 24a. Was an icate has autopsy 1 Tyes Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 ☐ Yes 2 🗓 No Hospital Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury Certificate: the Hospital or Attending 1 Natural 5 Pending injury 1 Yes 2 No Funeral Director: A Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) 1 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) D57531 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) mohita Veterans Ma 8601 State MAR 0 1 2012

DHMH 17 Rev 06-2011

Registrar

3altimore, Maryland 21215-0036

P.O. Box 68760

Records,

Division of Vital

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ February 26, Louise Wachter 2012 Emma 11 a. Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City. Town, or Location of Death 4c. County of Death Sandy Spring Montgomery Brook Grove Center Social Security Number If Under 24 Hrs. 7. Age (In yrs. last birthday **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign Months Hours Min 1 □ M 2 🏋 F 86 07/15/1925 **Director** 220-26-5711 Maryland Usual Residence of Decedent 28a-f show 10a, State 10c. City, Town or Location 10d. Inside City Limits the Maryland Director notified MD Burtonsville Montgomery 1 Tes 2 No 10e. Street and Number 0 10f. Zip Code 10g. Citizen of What Country? ian "natural", or items 23a o Medical Examiner must be Funeral 20866 United States 2930 Miles Road Page 1 and 2 should be filed within 72 hours after death 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Armed Force Black, White, etc "natural", or þ 1 Never Married 2 Married ☐ Yes 2 X No Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify. White Specify: Completed 3 X Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Il Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) the 12 Bank Teller Banking Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) of Health and Mental H fitem 27 is marked ot r other traumatic ever ပ Esther Ruth Greene Winfred E. Baker 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health a 2930 Miles Road, Burtonsville, MD 20866 Ruth Ann Miles / daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State Date 10 F P 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Department of Important: If any injury or 4 Donation 5 Other (Specify) Clustered Spires Cem. 03/01/2012 Frederick, Maryland . Signature of Funeral Service Licensee 22. Name and Address of Facility Reeney & Fastord Funeral Flome MO1222 106 E. Church St., Frederick, MD 21701 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line Interval Between Immediate Cause (Final Onset and Death Days Ph_sician/ disease or condition resulting in death) <u>Acute Tubular Necrosis</u> Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Fixer Uncertying Examine Due to (or as a consequence of): the attending physician and thed for use as the burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No been signed by the atte should be detached for ☐ Live BITT ∠ ☐ 1000 ☐ Pregnant at time of death ☐ Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy within 24 hours after death.

To the Funeral Director: After this certificate I completed filled in by the funeral director, page 1 Yes 2 No Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital 1 Inpatient 2 ER/Outpatient 3 DOA 4 X Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28b. Time of 28a. Date of injury (Month, Day, Year) Certificate: 28c. Injury at 28d. Describe how injury occurred 1X Natural injury work? 1 ☐ Yes 2 ☐ No 5 Pending Accident Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 [Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certi 29c. License number 29d. Date signed (Month, Day, Year) f hysicies D0055694 February 29, 2012

Registrar

DHMH 17 Rev 7/2009

0

4000 Rt. 108 Olney, MD 20832

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Dr. Alok Mathur

31. Date filed (Month

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ Gladys Marie Warnick 03 2012 7:30 റ6 Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner Allegany Frostburg Village Nursing Center Frostburg 4 Hrs. Min. Age (In vrs. last hirthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🗆 M 2 🗶 F Months Days Hours 03-11-1-1921 90 Mary Land 213-24-6265 Director Usual Residence of Decedent 28a-f show 10c. City, Town or Location 10b. County 10d. Inside City Limits 10a. State Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. **Funeral Director** ems 23a or 28a-f sh r must be notified a MD Allegany Frostburg 1 X Yes 2 No 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21532 219 West Main Street items Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status "natural", or ite Black, White, etc. by 1 Never Married 2 Married 1 Yes 2 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 💢 No Specify: White If Yes, Give Year or Dates Completed 3 Widowed 4 Divorced er than "natur the Medical E 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Department of Health and Mental Hygiene. Important: If item 27 is marked other tha any injury or other traumatic event, the Nonce. Own Home Homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Verna Beeman Fazenbaker Clarence Fazenbaker 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 117 West Main Street Frostburg, MD 21532 Leota Foye daughter 20b. Place of Disposition (Name of 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State rostburg Mem Park 3-9-2012 Frostburg, MD 4 Donation 5 Other (Specify) 22. Name and Address of Facility Sowers Funeral Home. P.A. 60 W. Main Street Frostburg, Md 21532 21. Signature of Funeral Service Licensee M00547 Man Ewes. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ condio vascular Atterosclerotic disease or condition Medical resulting in death) **Examiner** Sequentially list conditions, Due to for as a consequence of, Examine if any, reading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events burial-tran and Due to (or as a consequence of). resulting in death) Last physiciar Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 the as attending IF FEMALE: use 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery ☐ Ectopic pregnancy ☐ Other (specify) ____ in the past 12 months?

1 Yes 2 No
9 Unknown for Day Month Year Pregnant at time of death signed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Tes 2 No 3 Probably 4 Unknown Certificate: To Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No page 2 s 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 2 No Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) hours after death. neral Director: After this 28a. Date of injury (Month, Day, Year) . Manner of Death 28b. Time of funeral 28c. Injury at 28d, Describe how injury occurred iniury 1 Natural 2 Accident 5 \square Pending work? 2 🗌 No the f Investigation Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide determined within 24 hours a **To the Funeral C**completed filled Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 20b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year, 00055325 March 06, 2012

State Registrar

DHMH 17 Rev 7/2009

NONSOCK

31. Date filed (Month, Day, Year,

Bishop

walsh Rd Cumberland MD 21502

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

SHI

MD

925

32. Registrar's Signature

1-

Examiner

Physician/Medical

Be Completed by

Medical Certification: To

31. Date filed (Month, Day, Year)
MAR 1 9 2012

To Be Completed by Funeral Director

Physician /Medical Examiner

Registrar Decedent's Name (First, Middle, Last, Marion Louise Wi Facility Name (If not institution, give Frostburg Village Social Security Number 6. Se					Death			No. 🐪		
Frostburg Village						2	2. Date of Death Month	-	Voor	3. Time of Death
Frostburg Village	ntermver						03 1	Day 2	Year 2012	2345 ™
			4b. Cit	y, Town, o	or Location of	of Death		4c. Coun	ty of Death	
Capial Capusib, Number Co.				rostl		0411		A11	egany	(2)
10	TM 2 F	vrs. last birthda Yrs.	Month	er 1 Year s Days	If Under Hours	Min.	B. Date of Birth (Month, Day, Y	ear)	Coun	
215-20-5644		98					02-06-1	914	Mary.	Land
a. State 10b. County	10c	City, Town or	Location						10	Od. Inside City Limits
MD Allegan	ıv :	Frostbu	re							1 ☐ Yes 2 No
e. Street and Number				Zip Code			10g	. Citizen o	f What Coun	try?
0037 Parkersburg	Road NW			2153	2			U.S.	Α	
. Marital Status	12. Was Decedent Ever i Armed Forces?	n U.S. 1	3. Was Dec	cedent of F pecify Cub	Hispanic Ori oan, Mexicar	gin? (Spec 1, Puerto R	ify Yes or No- ican, etc.)		ace - America ack, White, e	
1 Never Married 2 Married	1 ☐ Yes 2 XNo			21 X No			,	Spec	rify:	_
3 Widowed 4 Divorced	Year or Dates:	100 D:	nodonia III	eual Occur	nation		40		Wh:	ite
15. Decedent's Edu (Specify only highest grad	le completed)	(Gi	cedent's Us ve kind of ver. DO NOT	work done	during mos	t of working		u. MING OF	Business/Ind	iualiy
Elementary/Secondary (0-12)	College (1-4or 5+)		Cash		,			Fra	iit Mai	rket
. Father's Name (First, Middle, Last)				L	18. Mothe	er's Name (First, Middle, Ma			
James Wintermyer					Nett	tie B	Lubaugh	Winte	ermyer	Myers
a. Informant's Name/Relationship (7)	vpe. Print)	19b. Ma	iling Addre	ss (Street			Route Number, C			
Jessie Porter	sister	100	37 Pa	rker	sburg	Road	NW Fros	tburg	, MD	21532
a. Method of Disposition	20	b. Place of Dis	position (A	lame of	ice)	Da	te 20	c. Location	- City or To	wn, State
1 ■ Burial 2 □ Cremation 3 □ F 4 □ Donation 5 □ Other (Specify)		Eckhart				3-15	-2012	Eckha	rt, M	O
. Signature of Funeral Service Licens	see		22. Name	and Addre	ess of Facilit	ty Sor	wers Fun	eral	Home	РΔ
Adan my So	aves Moos	747	60 M	J. Ma	in Sta		Frostbur		,	
3a. Part1. Enter the disease, or composite shock, or heart failure. List only o	ne cause on each line			ode of dyi	ing, such as	cardiac or				Approximate Interval Between
nmediate Cause (Final sease or condition	AR	vana	d	Der	nont	18				Onset and Death
sulting in death)	Due to (or as a cor	sequence of):								5
equentially list conditions,	b									
any, leading to immediate	Due to (or as a cor	sequence of):								
ause (Disease or injury at initiated events sulting in death) Last	c									
suiting in death) Last	Due to (or as a cor	sequence of):								
•	d									
FEMALE:	23c If was outcome of no	agnapou								
3b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome pf pro	Fetal death	3 □Ectopic		су				Date of delive Month	ery Day Year
1 ☐ Yes 2 ☐No 9 ☐ Unknown	4□Pregnant at time 9□Unknown	oi death	5 🗆 Other	(вреспу) _						
rt II. Other significant conditions co	ontributing to death but not	resulting in the	underlying	g cause giv	ven in Part I		23e. Did toba	cco use co	ontribute to th	ne cause of death?
-				J			1 ☐ Yes	2□ No	3 □ Prob	ably 4 Naknowr
							24a. Was an	0.41	h More sut-	ney findings available
							24a. was an autopsy performe	ed?	prior to con death?	psy findings available mpletion of cause of
							1□ Yes 2	No	1 🗆 Yes	2□ No
		offer out	oF	DOA Oth			(Check only one)			
examiner?	Hospital:	2 ER/Outpat	ient 3	DOA	4 🗷 Ni	ursing Hom	e 5 ☐ Residen		Other (Specif	y)
examiner? 1 Yes		28h Time	e of	28c Iniu	Irv at	1 21	Rd. Describe how	injury occ	urred	
1 Yes No	Hospital: 1 ☐ Inpatient 28a. Date of Injury (Month, Day Yea	28b. Time Injur	У	28c. Inju Wo			3d. Describe how	injury occ	urred	
examiner? 1 Yes 2 No Manner of Death 1 Natural 5 Pending investigation 3 Suicide 6 Could not be	28a. Date of Injury (Month, Day Yea	nr) Injur	y M	1	Yes 2□	No				d Route Number.
examiner? 1 Yes 2 No Manner of Death 1 Natural 5 Pending investigation	28a. Date of Injury	nr) Injur	y M	1	Yes 2□	No	Bf. Location (Stre City or Town,	et and Nui		d Route Number,

State Registrar 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's S

1244

rostburg MD 21532

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible

				State of Maryla	nd / Depa		lealth and M	fental Hygi	ene	08562
			Registrar		CE	illicate of	Dealii	2. Date of Death	g. No. C	3. Time of Death
	Physicia	an	Decedent's Name (First, Middle, Last)					Month	Day Year 2 2012	4:59 p.M
	/Medic		Susan E. Witmer					March		4.00 p.m
*	Examin	er	4a. Facility Name (If not institution, give sti	reet and number)		4b. City, Town, o	r Location of Death		4c. County of Death	
E			Mennonite Fellowsh			Hagerstow If Under 1 Year	If Under 24 Hrs.	O Date of Birth	Washingto	
	Funeral		5. Social Security Number 6. Sex	7. Age (In yr:	s. last birthday) Yrs.	Months Days	Hours Min.	8. Date of Birth (Month, Day,		place (State or Foreign intry)
	Director		175-03-2386 Usual Residence of Decedent	95	113.			March 7	1916	
	and and		10a. State 10b. County	10c. C	City, Town or Lo	ocation			1	0d. Inside City Limits
	r sho	ō	Maryland Washingto	n u						1 ☑ Yes 2 ☐ No
	28a-	Director	10e. Street and Number	11 Ha	gerstown	10f. Zip Code		10	g. Citizen of What Cour	ntry?
	with so a	<u> </u>				21740			J.S.	
	ns 23	Funeral	12349 Huyett Lane	2. Was Decedent Ever in	U.S. 13.		dispanic Origin? (Span, Mexican, Puerto		14. Race - Americ	can Indian,
	ter o	F.	1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 ☑ No				Rican, etc.)	Black, White,	etc.
	urs a	by	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:		1 ☐ Yes 2 ☑ No	Specify:		Specify: Whi	te
5	illed within 72 hours after death with the Maryland Hygiene, withen "naturel", or Items 23e or 28e-f show bith, the Medical Examir etc. statter rediffed at	Completed	15. Decedent's Educa	ation	16a. Dece	dent's Usual Occup	ation during most of work		6b. Kind of Business/In	dustry
-	Mad "	ple	(Specify only highest grade Elementary/Secondary (0-12)	College (1-4or 5+)	life.	DO NOT use retire	d)	ing		
7	giene giene	Ю	8		Hon	nemaker			Own Home	
2	oth oth	Be (17. Father's Name (First, Middle, Last)				18. Mother's Nam	e (First, Middle, M	laiden Sumame)	
<u>a</u>	Venta Venta rrked ritic e	10	Maurice Mentzer				Martha	Sollenbe	rger	
5	and I		19a. Informant's Name/Relationship (Type	e, Pnnt)					City or Town, State, Zip	
2	permit. Peges 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If teem 27 is marked other than "natural, or flems 23a or 28a-f show any injury or other traumatic event, the Medical Examination and the inclinical at Once.		Robert Witmer				Road, Ch			
ב ב	of H of H fiter		20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Re	14 21-1-	cemetery, cre	osition (Name of matory or other pla	ce)	Date 2	Oc. Location - City or To	own, State
	Peg nent ant: I		`4 □Donation 5 □ Other (Specify)	Sto	oughstowr	Mennonite	Cem. 3-6-2	2012 N	ewville, PA	
<u></u>	permit. Departi Importi any inj		21. Signature of Funeral Service License			2. Name and Addre	ss of Facility	112 W. K:	ing St.	
<u> </u>	205 = 9		23a. Part 1. Enter the disease, or complic	m013					ourg, PA 17257	7 Approximate
	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Functed Director: After this certificate has been signed by the attending physician and positive completely filled in by the funeral director, page 2 should be detached for use as the burial-transit or be be been been been been as the burial-transit.	cal Examiner	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last d.	Due to (or as a consi	equence of):	c md	<u>diant</u> en sio	die hei	rs I gailure	Onset and Death
00	ificati g phy as the	edic	<u> </u>							
.O. DOX	the death cert y the attending ached for use	Physiclan/Medl	IF FEMALE: 23 23b Was decedent pregnant in the past 12 months? 1 □ Yes 2 No 9 □ Unknown	lc. If yes, outcome of preg 1 ☐ Live birth 2 ☐ Fe 4 ☐ Pregnant at time o 9 ☐ Unknown	etal death 3	□Ectopic pregnanc □ Other (specify) _	у		23d. Date of deliv Month	ery Day Year
Ĺ	s that pred to e det	by P	Part II. Other significant conditions cont	ributing to death but not r	esulting in the	underlying cause gr	ven in Part I.	23e. Did tob	acco use contribute to t	
ecords,	quire en sig		- Acuil 70	mal go	MUN	2		1 ☐ Ye	s 2. ZNo 3 □ Pro	bably 4 Unknown
ວ	aw re s bei	Completed		U				24a. Was ar autopsy	24b. Were auto	opsy findings available ompletion of cause of
č	The Ite ha	E						perform	ed? death? ⊠No 1 ☐ Yes	_
V 11.01	rtifica tor, p	0	25. Was case referred to medical				26. Place of Dea	th (Check only one		
_	nyste direc	To B	examiner?	ospital: 1 Inpatient 2	☐ ER/Outpatie	ent 3 DOA	her: 4 Nursing H	ome 5 Reside	nce 6 Other (Speci	Mirine Ancil
5	neral		27. Manner of Death 1 Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time (of 28c. Inju	ry at	28d. Describe ho	w injury occurred	×. 0 ,
Division	ath. Pr: Af	atle	2 ☐ Accident investigation			M 1	Yes 2 □No			
<u>"</u>	recto	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - Albuilding, etc. (Spe		treet, factory, office		28f. Location (Str City or Town	eet and Number or Aur , State)	al Route Number,
2	rs aff									
	Hosp 4 hou Funei ely fil	ical	(Check only 2 Medical Examin	ician: To the best of my ker: On the basis of exam	nowledge, dea ination and/or i	th occurred at the to nvestigation, in my	me, date and place opinion, death occu	, and due to the ca rred at the time, da	luse(s) and manner as : ite and place, and due !	stated. to the cause(s)
	the hin 2 the f	Medical	one)	and manner stated.		29c. Licen			d. Date signed (Month,	
	70 Vit	-	29b. Signature and title of certifier			Z.Sc. Licell	/ Z 0 5	2	00/2/	10/2
1	ma (and ar	/wacı	00-1	Die	6223))	03/00/3	10(4
	2 21 C		30. Name and address of person who cor	mpleted cause of death (I	tem 23a) (Type	A/	orthes	in Ano	Hacenton	MMX
	Sta	ite	31. Date filed (Month, Day, Year)	32. Registrar Sig	natire	1	0 - 1 - 1 - 1	1 1 10) // //	(1)
	Registi		MAR 1 9 2012	Exercis A.	Harry					

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ Barbara 2029 PM 04 2013 Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Prince Frederick Calvert Calvert Memorial Hospital If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Davs Hours November 4, 1948 MD **Director** 219-48-4777 63 Usual Residence of Decedent 28a-f shov 10a. State 10c. City, Town or Location at 10b. County 10d. Inside City Limits death with the Maryland Director iral", or items 23a or 28a-f s Examiner must be notified 1 Yes 2 No MD Saint Marys Mechanicsville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20659 USA 29864 Grant Road 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces? Black, White, etc. 1 Never Married 2 Married by Baltimore, Maryland 21215-0036 within 72 hours after If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: "natural", Completed 3 Divorced 4 Divorced White the Medical 16a. Decedent's Usual Occupation
(Give kind of work done during most of working 15. Decedent's Education 16b, Kind of Business Industry (Specify only highest grade completed) al Hygiene. I other than " life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) **Power Plant** Receptionist Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) th and Mental H 27 is marked of traumatic ever ပ Katherine Rawley Robert Cates permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any injury or other traumatic 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2120 Oak Road Port Republic, MD 20676 19a. Informant's Name/Relationship (Type, Print) Bobbi Bennett - daughter 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 ☐ Burial 2 🖼 Cremation 3 ☐ Removal from State Metropolitan Crematory February 29, 2012 Alexandria, VA 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Sewell Funeral Home, P.A. 21. Signature of Funeral Service Licensee 1451 Dares Beach Rd. Prince Frederick, MD 20678 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph. sician/ Hypercapuec days disease or condition Medical resulting in death) Due to (or a consequence of) Examiner COP Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine artending physician and for use as the burial-transit Cause (Disease or linjury that initiated events resulting in death) Last or Attending Physician: The law requires that the dea h ceraficate be executed Due to (or as a consequence of) Physician/Medical Box 68760 IF FEMALE: / the artending the definition of the design 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Day Year Pregnant at time of death 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? signed to þ Division of Vital Records, 1 X Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an s certificate has b lirector, page 2 s autopsy performed? Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? 1 \square Yes Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No မှ 1 Inpatient 2 ER/Outpatient 3 DOA After this funeral 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending work? 1 Yes 2 No n 24 hours after death.

e Funeral Director: Aft
bleted filled in by the fur Accident Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 To the F 29b. Signature and title of certifier 29c. License number 29d, Date signed (Month, Day, Year) D0061783 2012 26 30. Name and address of person wife completed cause of death (Item 23a) (Type, Print) JRN Hospital Road Prince Frederick MD 201278 Choi 100 MD nana 31. Date filed (Month, Day, 32. Registrar Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Physician/ Royal J. Young, Sr. Februar 2012 2:10 Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Centreville Queen Anne's Corsica Hills Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Hours Months 227-20-3943 85 1 🛛 M 2 🗆 F **Director** July 05,1926 Virginia Usual Residence of Decedent 28a-f shov 10d. Inside City Limits 10b. County 10c. City, Town or Location must be notified at 10a. State Director MD Anne Arundel Arnold 1 Yes 2 XNo 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? ō Funeral items 23a 307 Clifton Avenue 21012 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 1. Marital Status er than "natural", or iter the Medical Examiner rmed Forces?

XYes 2 \sum No Black, White, etc. þ 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 X No Specify. White Year or Dates. WW II Specify: Completed 3 ♥ Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 2 should be filed within 72 h and Mental Hygiene. 7 is marked other than "r Technology & Elementary/Secondary (0-12) College (1-4 or 5+) Development Civil Engineer permit. Page 1 and 2 should be filed w Department of Health and Mental Hyg Important: If item 27 is marked othe any injury or other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) unk မ James Riley Young Eunice 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Barbara Delph / Daughter <u>307 Clifton Avenue Arnold, MD 21012</u> Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 28, 20c. Location - City or Town, State Feb. 1 \square Burial 2 X Cremation 3 \square Removal from State Baltimore, MD Metro Crematory, INC. 4 ☐ Donation 5 ☐ Other (Specify) 2012 22. Name and Address of Facility
Barranco & Sons, P.A. Severna Park Funeral Home
495 Ritchie Hwy, Severna Park, MD 21146 21. Sign I re of uneral Service Lic n Approximate Interval Betwe Onset and Year a Ente the disease, or complice ock, or he int failure. List only one tions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Onset and Math Imp ediate Caus (Final d'sease or con ition esulting in de th) Physician/ Medical Examiner vars uentially list conditions, if any, leading to immediate cause. Enter Underlying ulars Exami burial-transi and resulting in death) Last nears attending physician Physician/Medical certificate be the 88 IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No ξ Pregnant at time of death 5 Other (specify) be detached signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy Yes 2 1 Yes 2 No funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? 1 Tes 2 X No ၟႄ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) 28c. Injury at work?
1 ☐ Yes 2 ☐ No 28b. Time of 27. Manner of Death 28d. Describe how injury occurred 1 Natural injury 5 \square Pending Accident Investigation Could not be 28f. Location (Street and Number or Rural Route Number,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1 Decedent's Name (First Middle | ast) 2. Date of Death Physician/ Year 5:11 AM Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death of May land Medical Baltimore Baltimore If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Min. Director 149-26-8420 80 1 🕱 M 2 🗆 F 2/20/1932 DE 10b. County 10c. City, Town or Location 10d. Inside City Limits ns 23a or 28a-f sho must be notified at Director 1 Yes 2 X No E1kton MD Ceci1 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? permit. Page 1 and 2 should be filed within 72 hours after death with 1 Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a any injury or other traumatic event, the Medical Examiner must by once. Completed by Funeral USA 21921 20 Duck Hollow Drive 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S 11. Marital Status 14. Race - American Indian. 1 Never Married 2 Married 1 X Yes 2 If Yes, Give Year or Dates. Saltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: White 3 Widowed 4 Divorced 1954-56 Decedent's Usual Occupation (Give kind of work done during most of working life, DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4 or 5+) Chemical Sales Consulant Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Ilse Ahlemann Kurt S. Zeise 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20 Duck Hollow Drive, Elkton, MD_21921 Phyllis Zeise - wife 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State cemetery, crematory or other place) Rising Sun, MD 4 ☐ Donation 5 ☐ Other (Specify) T. Foard Funeral Home, PA 21. Signature of Funeral Service Lic 22. Name and Address of Facility R.T. Foard Funeral Home, 111 S. Queen Street, Rising Sun, MD 21911 23a Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line. Immediate Caus Final disease or condition resulting in death) Onset and Death Ph_sician/ Stitial Medical Due to (or as a consequence of) Examiner Sequentially list conditions, Examine cause. Enter Underlying Cause (Disease or injury Dise to for as a consequence of and I-transit that initiated events as the burial-t resulting in death) Last Due to (or as a consequence of): Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 the attending IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ detached for in the past 12 months?
1 Yes 2 No Pregnant at time of death 1 ☐ Yes 2 ☐ Unknown Unknown signed by t d be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown 1 Yes Director: After this certificate has been side in by the funeral director, page 2 should I 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an performe 2 No 1 Yes filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital Other: 2 No ျှ 1 🗌 Yes 1 ☑Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27, Manner of Death Certificate: 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred Natural 5 Pending Accident Investigation 3 Suicide
4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined To the Hospital within 24 hours a To the Funeral L Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifie 740597038 MD

Registrar
DHMH 17 Rev 06-2011

State

20111A

GRENA

STREET BUILDINGS

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

22

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

amend item 8 per fh g928 6-12-12 vt
State of Maryland / Department of Health and Mental Hygiene

		-	for State of Maryland / t		ficate of D		, 0	g. No. 🤈 [112	08566
	Physicia		1. Decedent's Name (First, Middle, Last) Edna M. Adams				2. Date of Death Month	Day 15	Year	3. Time of Death
The same of the sa	Medic Examin		4a. Facility Name (if not institution, give street and number)		b. City, Town, or	Location of Death	I letter out	4c. County	of Death	
	Funeral Director			hday) I	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bi rtly (Month, Day, Y	L		
	//aryland // Sa-f show tified at	Director	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town MD N/A Balt				<u> </u>	-	1	l 0d. Inside City Limits 1 Yes 2 □ No
	with the N 23a or 2 ust be no		10e. Street and Number 117 Cator Ave.		10f. Zip Code 2121	8	10	g. Citizen of	What Cour	ntry?
980	be filed within 72 hours after death with the Marylano antal Hygiene. Add other than "hatural", or items 23a or 28a-f show ked other than "hatural", or items 23a or 28a-f show fee ornt, the Medical Examiner must be notified at		11. Marital Status 1 □ Never Married 2 □ Married 3 ☑ Widowed 4 □ Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Yes 2 ☑ No If Yes, Give Year or Dates.		s Decedent of His es, specify Cubar Yes 2 X No	panic Origin? (Sp , Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	Bla	ce - Americ ck, White, : Bla	etc.
Maryland 21215-0036	ithin 72 hou ene. r than "natu the Medica	Completed by	(Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+)	(Give kind life. DO N	nt's Usual Occupa d of work done do NOT use retired)	tion uring most of work	ring	6b. Kind of E		dustry
land 2	buld be filed w d Mental Hygi marked other matic event, t	To Be	17. Father's Name (First, Middle, Last) Morris Comegy	DOMO	,5010		ne (First, Middle, Ma . Green			
	shown han 7 is trau		19a. Informant's Name/Relationship (Type, Print) Catherine P. Chase-Daughter				al Route Number, C Baltimor			
Baltimore,	- 5 E C		4 ☐ Donation 5 ☐ Other (Specify) Mt. Z	ry, cremati ion	tory or other place Cenete	ry 3/23	/2012 L	oc. Location	wn,	MD
Ball	permit. Page Department Important: I any Injury o	7	21. Signature of Auneral Service Licensee	22. N NC	lame and Address orth Av	s of Facility Ma e. Balt	rch F/H	-East MD 21	202	I E.
x 68760 Ng	Ph_i i.i.a.n Medical Examiner pnuial-transit	cal Examiner	23a. Part 1. Enter the disease, or complications that caused the death. Do not shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that Initiated events resulting in death) Last Due to (or as a consequence of the conditions) Due to (or as a consequence of the condit	of):	In Far		or respiratory arresi			Approximate Interval Between Ons t and Death
Bo	is that the death certificate be executed gened by the attending physician and be detached for use as the burial-transit	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1		Ectopic pregnancy Other (specify)				ate of deliv	rery Day Year
<u>ч</u> .	uires that th n signed by uld be deta	by	Part II. Other significant conditions contributing to death but not resulting in	n the und	lerlying cause give	en in Part I.				he cause of death? bably 4 □ Unknown
Division of Vital Records,	sician: The law requires that s certificate has been signed I director, page 2 should be det	Completed					24a. Was an autopsy perform 1 Yes 2		Were auto prior to co death? 1 \(\sum \) Yes	psy findings available ompletion of cause of
f Vital	the Hospital or Attending Physician: The Abours after death, the Funeral Director: After this certific mpletely filled in by the funeral director,	To Be	25. Was case referred to medical examiner? 1 Yes 2 No	utpatient Time of	3, DOA Othe	4 ☐ Nursing H	ome 5 Residen			y)
sion o	Attending r death. ctor: After by the fune	Certificate:		njury		Yes 2 No	28d. Describe how 28f. Location (Stre	et and Numl		l Route Number,
<u>N</u>	ospital or hours afte uneral Dire	Medical Ce	29a. Certifier 1 Certifying Physician: To the best of my knowledge,	death occ	curred at the time	date and place, a	City or Town, and due to the caus	e(s) and mar	ner as stat	ted.
	To the Hospital or Attending Phys within 24 hours after death. To the Funeral Director: After this or completely filled in by the funeral dir	Me	(Check 2 ☐ Medical Examiner: On the basis of examination and/only one) 3 ☐ Certifying Nurse Practitioner: To the best of my known 29b. Signature and title of certifier		eath occurred at the 29c. License	e time, date and p	ace, and due to the	cause(s) and d. Date signe	manner as ed (Month,	stated. Day, Year)
	10		30. Name and address of person who completed cause of death (Item 23a) (Type, Prin		3373 East Uni	versity Par laryland	larch kwa y		0017
	Star		Paul Kong Union Memorial Hospital 31. Date filed (Month, Day, Year) MAR 2 0 2012 Leven S. Sark	. , -	Balti	more d	lanyland	212/8	-	
	Registra	ar	MAR 2 0 2012 General S. Save	Birde						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Harry Benjamin Adams Physician/ 16, March 2012 3:30 A. M Medical 4a. Facility Name (if not institution, give street and number, 4b. City. Town, or Location of Death 4c. County of Death Examiner Baltimore County Hampton Meadows Assisted Living Towson If Under 24 Hrs. Social Security Number 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) If Under 8. Date of Birth **Funeral** Davs Hours 215-01-8348 1 **X**M 2 □ F Director Dec. 28, 1912 Baltimore, MD. Usual Residence of Decedent 28a-f show 10c. City, Town or Location 10a. State 10d. Inside City Limits the Maryland aţ Director notified 1 🗆 Yes 2 🔀 No Baltimore County Maryland 10e Street and Number 10f. Zip Code ō Citizen of What Country' must be United States 23a Funeral 21286 1412 Providence Road 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) death 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian Was Deceden.
Armed Forces?
1 Yes 2 No Examiner Black, White, etc. o þ 1 Never Married 2 Married 1 Yes 2 If Yes, Give Year or Dates Maryland 21215-0036 within 72 hours after 1 ☐ Yes 2 X No Specify: Specify: White "natural" Completed 3 Widowed 4 Divorced Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life, DO NOT use retired) al Hygiene. College (1-4 or 5+) Elementary/Secondary (0-12) the Continental Can Shipping Office 12 N/A event, 1 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental F ပ Henry Adams Louise Henry traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ellicott City, MD. 21043 it of Health a 13175 Folly Quarter Road Mr.Richard A. Kohr, Jr. (Executor) other t Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of (Harford County) Evers Fureral Chapel and Cremation Services, Inc. 1 Burial 2 Cremation 3 Removal from State March 19, Department or Important: If any injury or injury or 4 ☐ Donation 5 ☐ Other (Specify) Forest Hill, Maryland 2012 of Funeral Service License Effrey L. Gair, Sr. (152) 2 Pencerul Alternatives Funeral and Cremation Center, P.A. Lic.#M00677 2325 York Road Timonium, Maryland 21093-2215 t 1. Enter the disease, o ock, or heart failure. List o complications that caused the death. Do not enter the mode of dving, such as cardiac or respiratory arrest, Immediate Cause (Final Onset and Death accuoma Physician/ disease or condition Medical resulting in death) **Examiner** 2 Money Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Cause (Disease or injury that initiated events resulting in death) Last the burial-trai attending physician Physician/Medical P.O. Box 68760 use as IF FEMALE: yes, outcome of pregnancy
Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months? for Month Day Year Pregnant at time of death signed by the at d be detached for Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown Division of Vital Records, 1 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has, page 2 this certificate 2 No 1 Yes or Attending Physician: 25. Was case referred to me the funeral director. Be 26. Place of Death (Check only one) examiner? Other: 1 Tes 2 1 Certificate: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Spec 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director: After injury Matural 5 Pending 1 Yes 2 No Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined the Hospital Medical 29a. Certifier 📝 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) and title of certifie 29b. Signature 29c. License numbe

State

Registrar

ype, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #5&18 Per FH 6926 4/12/2012 JH of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Valentino Aquilano March 15,2012 6:00 A. M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore County Towson Gilchrist Hospice Center 1 Year If Under 5. Social Security 1970 7 214-24-1407 If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** Days Hours March 03,1928 Baltimore, MD. Director 84 Yrs Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits death with the Maryland Director 3a or 28a-f sh Parkville Maryland Baltimore County 1 Yes 2 No 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? ms 23a must be United States Funeral 21234 3211 Texas Ave. items 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian. 11. Marital Status Black, White, etc. 0 þ 1 Never Married 2 Married Yes 2 X No Page 1 and 2 should be filed within 72 hours after Baltimore, Maryland 21215-0036 White 1 Yes 2 No Specify Give Specify "natural". 3 Widowed 4 Divorced Completed Year or Dates Medical 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) ed other than " Elementary/Secondary (0-12) College (1-4 or 5+) 08 N/A Tire Mechanic Firestone Department of Health and Mental Hygier Important, If item 27 is marked other t any injury or other traumatic event, the once. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Carrie Russo Carmela Rizzo Anthony Ferdinando Aquilano 19a. Informant's Name/Relationship (Type, Print) (Wife) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Parkville, Maryland 21234 3211 Texas Ave. Mrs.Joan Felisa(nee Gonzales)Aquilano 20a, Method of Disposition 20b. Place of Disposition (Name o 20c. (Baltimore County) Dulaney Valley Mellocial Monday, March 19,2012 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Timonium, Maryland 4 Donation 5 X Other (Specify) Entonoment Funeral Serve License Jeffrey L. Cair, Sr. OFSP 2 Name and Address of Facility ves Funeral and Cremation Center, P.A.

Percentul Alternatives Funeral and Cremation Center, P.A.

2325 York Road Timonium, Maryland 21093-2215 21. Signatur Part 1. Enter the disease, by complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final schemicacute tobolar necros is Pnysician/ disease or condition Jack 6 resulting in death) Medical Due to (or as a consequence of) Examiner 2-STAZ urtensing Sequentially list conditions, Due to (dr as a consequence of) Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Hospital or Attending Physician: The law requires that the death certificate be executed burial-trai that initiated events Due to (or as a consequence of) resulting in death) Last physician Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 the use as IF FEMALE: 23d. Date of delivery 23b. Was decedent pregnant for in the past 12 months? Month Day ed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. s certificate has been signed I director, page 2 should be det 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Inknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) NOS PCG Hospital: ပ 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA filled in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending injury work? 1 ☐ Yes 2 ☐ No Accident Investigation hin 24 hours after deal the Funeral Director; 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier within 24 ho

To the Fune

completely f Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Contribute Nurse Fractitioner To the best of my in evil age death contribute the time, date and place, and due to the naturally and manner stated. (Check and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signatu 30 March 15 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) AMINES CV Charles 6701

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend 19a per fb 9925 3-29-12 sm State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 2012 Year 5

3. Time of Death

Physician /Medical Examiner **Funeral** Director Director

r than "natural", or items 23a or 28a-f show by Funeral Completed Pages 1 and 2 should be filed wi tment of Health and Mental Hygien tant: If item 27 is marked other th jury or other traumatic event, Its Be ပ f Health item 27 i

Physician /Medical Examiner

Department of H Important: If iten any injury or otl once.

altimore, Maryland 21215-0036

The law requires that the death certificate be executed physician and s the burial-trans attending p the signed by t. d be detach ospital or Attending Physician: The hours after death. uneral Director: After this certificate ly filled in by the funeral director, par Hospital

P.O. Box 68760,

Division of Vital Records,

9:25 A M Joshua R. Adepoju 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Columbia Howard Lorien Nursing Home If Under 1 Year | If Under 24 Hrs. | Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) March 19,1935 5. Social Security Number 6 Sex 7. Age (In vrs. last birthday) Days Min 187 M 2 □ F 219-64-1658 76 Nigera Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 1 ☐Yes 2 X No Prince George Clinton Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? U.S.A. 3106 Glissade Court 20735 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 ∐Yes 2 X No If Yes, Give Year or Dates: 1 ☐ Never Married 2 X Married 1 ☐Yes 2XXINo Specify: 3 Widowed 4 Divorced Black. 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Security Officer Private 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) James Adepoju 19a. Informant's Name/Relationship (*Type. Print*) **Chadebo. Adepoju**(Son) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3106 Glissade Court Clinton, Maryland 20735 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1
☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 3-30-2012 Meadowridge Memorial Park Elkridge, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Witzke Funeral Homes, Inc. 21. Signature of Funeral Service Licenses Columbia, Maryland 21045 5555 Twin Knolls Road Approximate Interval Between Onset and Death 23a. Parfi. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final ASPIRATION PREVMONIA disease or condition resulting in death) Due to (or as a consequence of): Sugar Itally list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Physician/Medical Examiner that initiated events resulting in death) Last Due to (or as a consequence of) IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 5 ☐ Other (specify) 1 ☐Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by DYSPHAGIA, CEREBROVASCULAR ACCIDENTS 2 No 3 Probably 4 Unknown 1 🗌 Yes ENCEPHALOPATHY, 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an HYPERTENSION, SEIZURES. HYPOTHYROIDISM 2 No 1 ☐ Yes 1 ☐Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1☐ Yes 2☐ No Other: Certification: To 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

Registrar

Medical

(Check only one)

31. Date filed (Month, Day

29b. Signature and title of certifier

DHMH 17 Rev 1/2001

and manner stated.

6334

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

NARYLI

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

20069962

(Type, Print) CEDAR LANE, LORIEN, COLUMBIA, 21044

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Boots MARCH 15, 2012 12:40 AM C. Ellsworth Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner TOWSON BALTIMORE SAINT JOSEPH MEDICAL CENTER If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Social Security Number Age (In yrs. last birthday) **Funeral** Days Hours (Month, Day, Year) 216-12-6190 Director 1**火** M 2 □ F 88 23 MD 11 05 Usual Residence of Decedent r 28a-f show notified at 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location Director 1 Yes 2 XNo Pikesville MD Baltimore 0 10e. Street and Number 10g. Citizen of What Country? ıral", or items 23a or Examiner must be Funeral 7416 Campfield Road 21208 U.S.A. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-12. Was Decedent Ever in U.S 14 Race - American Indian ed Forces? Yes 2 No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 X Yes 2 If Yes, Give Year or Dates. þ 1 Never Married 2 Married hours after Maryland 21215-0036 an "natural", 1 ☐ Yes 2X No Specify: Black 3 Widowed 4 XDivorced Completed Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working should be filed within 72 h and Mental Hygiene. 7 is marked other than "r life. DO NOT use retired) College (1-4 or 5+) lementary/Secondary (0-12) the Tate Tempco Warehouse Worker 10th grade Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ပ Elsie Boardley Ernest Boots other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health an Important: If item 27 is 1 any injury or 27 7416 Campfield Road, Pikesville, Md 21208 Brice Boots-Son Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) cemetery, crematory or other place) 3/23/2012 Owings Mills, Garrison Forest Marchand Admis of acility 21. Signature of Fune unce 4300 Wabash Ave, 21215 Baltimore, Md 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death SEPTIC SHOCK Immediate Cause (Final Ph_sician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner URINARY TRACT INFECTION Sequentially list conditions, Due to for as a consequence of if any, leading to immediate cause. Enter Underlying Examir burial-transit Cause (Disease or injury that initiated events resulting in death) Last and Due to (or as a consequence of): physician Physician/Medical certificate be Division of Vital Records, P.O. Box 68760 the attending IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Day Month Year Pregnant at time of death the t signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 Yes 2 X No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an page 2 autopsy performed? Yes 2 X No death?
1 Yes 2 No io the Hospital or Attending Physician: The within 24 hours after death.

To the Funeral Director: After this certificate completely filled in the state. this certificate 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital 1 Tes 2**X** No 1 Ninpatient 2 ER/Outpatient 3 DOA ပ 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred 1 XNatural iniury 5 Pending M Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

12

State

Registrar

29a. Certifier

3 29b. Signature and title of certifier

MAR 20

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

FRANCIS KHOO, M.D. 7601 OSLER DRIVE TOWSON, MD 21204 31. Date filed' (Month, Day, Year)

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29d. Date signed (Month, Day, Year)

29c. License number

D30263

Patient From as! Esther Brandon

	Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.										
			For State	State of M	-	epartment of Healt Certificate of Deat	h	0016			
			Registrar 1. Decedent's Name (First,	, Middle, Last)		pertincate or Death	2. Date of De	Reg. No.	3. Time of Death		
	Physicia Medic		Esther	E1:	nora	Brandor	Marin	h 13 Year 20/2	2 10:46 PM		
3	Examin		4a. Facility Name (if not inst	stitution, give street and number)	Baltimur	4b. City. Town, or Location	on of Death	4c. County of Deat			
	Funeral		5. Social Security Number		e (In yrs. last birthd		der 24 Hrs. 8. Date of Birt	h 9 Birt	hplace (State or Foreign		
	Director		229-48-359	4 17 14 18 17 18	85 Yr	Months Days Hour		y, Year) Cou	intry) V A		
7	how	۱	Usual Residence of Decede 10a. State 10b. C	lent County	10c. City, Town o	r Location	0, 0,		10d. Inside City Limits		
- Park	Ba-f s tified	Director	MD	NA		imore			1 X Yes 2 □ No		
tho A	a or 2 be no		10e. Street and Number			10f. Zip Code		10g. Citizen of What Co	untry?		
th with	ms 23 must	Funeral	2316 Ocala			21215		U.S.A	•		
(O)	or ite	by Fu	11. Marital Status1 ☐ Never Married 2 ☐	12. Was Decedent B Armed Forces? 1 ☐ Yes 2 ☑	ever in U.S.	 Was Decedent of Hispanic If Yes, specify Cuban, Mexi 	Origin? (Specify Yes or No- can, Puerto Rican, etc.)	14. Race - Amei Black, White	, etc.		
21215-0036 with the Mandard	ural",	ted k	3 ₩Widowed 4 □ Div	ivorced If Yes, Give Year or Dates.		1 ☐ Yes 2🌠 No Spec	sify:	Specify: B1	ack		
15-("nat ledica	Completed	(Specify only	Decedent's Education ly highest grade completed)	(G	ecedent's Usual Occupation live kind of work done during n	nost of working	16b. Kind of Business I	ndustry		
212	other than		10th grade	(0-12) College (1-4 or 5 n a	5+)	Housewife		Home			
land	vent vent		17. Father's Name (First, Mi			18. M	other's Name (First, Middle,	Maiden Surname)			
ryla Market	narke	잍	McKinley C								
Baltimore, Maryland 21215-0036	of Health and Mental F fitem 27 is marked o r other traumatic eve		19a. Informant's Name/Relation Elaine E.	Brandon-Daug	hter 2	failing Address (Street and Nur 316 Oca 1 a A $_{5}$	mber or Rural Route Numbe. 7e, Baltimo	r, City or Town, State, Zip re, Md 21	215		
ore,	of Heal fitem		20a. Method of Disposition	n mation 3 Removal from State		isposition (Name of crematory or other place)	Date	20c. Location - City or	Town, State		
timo	tment tant: I		4 Donation 5 O	Other (Specify)	1		3/23/2012	Owings M	ills, Md		
Bal	Department of Limbortant: If ite any injury or ot once.		21. Signature of Funeral Se	ervice Licensee)	ke	Ma Pachard Adrias of โล 4300 Wabash	St Ave, Balti	more, Md	21215		
			23a. Parl 1. Enter the disea shock, or heart failure	ease, or complications that causes e. List only one cause on each line	the death. Do not				Approximate Interval Between		
	sician/ Medical	1	Immediate Cause (Final disease or condition resulting in death)	_a Compli	cations	Associateo	(with Hyp	extension	Onset and Death		
	xaminer		resulting in death)	Due to or as a	a consequence of):	Associated Heart Fa	aluce !				
		iner	Sequentially list conditions if any, leading to immediate cause. Enter Underlying	S. D.	a consequence of):	March 1					
executed	ian a nd irial-transit	Examiner	Cause (Disease or iinjury that initiated events	C							
			resulting in death) Last		a consequence of):						
Box 68760 death certificate b	g phys as the	Medi		d							
× 66	tendin or use	ian/l	IF FEMALE: 23b. Was decedent pregnar in the past 12 months?			3 ☐ Ectopic pregnancy		23d. Date of deli	· '		
. Bo	been signed by the attending physic should be detached for use as the bi	Physician/Medical	1 Yes 2 No	4 Pregnant at 9 Unknown	t time of death	5 Other (specify)		Month	Day Year		
P.O	ned by e detad	by Pt	Part II. Other significant co	conditions contributing to death b	ut not resulting in the	ne underlying cause given in Pa	art I. 23e. Did to	bacco use contribute to	the cause of death?		
'ds,	en sig ould b	ted					1 🗆 `	Yes 2 1 No 3 □ Pr	obably 4 🗌 Unknown		
SCO!	has be le 2 sh	Completed					24a. Was a autop	sy prior to c	opsy findings available ompletion of cause of		
A The	ficate or, pag		25. Was case referred to me	edical		00.5	1 🗆 Yes	rmed? death? 2 1 Yes	2 No		
Vita ysicia	is cert direct	To Be	examiner? 1	Hospital:	ent 2 L ER/Outpa	Other:	Peath (Check only one) Nursing Home 5 Resid	ence 6 Other (Speci	60		
of of Ph	fter th		27. Manner of Death	28a. Date of injur (Month, Day	ry 28b. Tim	e of 28c. Injury at		ow injury occurred	<i>y</i> ,		
Sion	death.	Certificate:	2 Accident II	Investigation	At hamp form	M 1 ☐ Yes 2					
Division of Vital Records, P.O. tal or Attending Physician: The law requires that the	s after		4 ☐ Homicide d	determined building, etc		street, factory, office	281. Location (S City or Tow	treet and Number or Run n, State)	al Houte Number,		
Division of Vital Records, P.O. Box 68760 for the Hospital or Attending Physician: The law requires that the death certificate be	within 24 hours after death. To the Funeral Director: After this certificate has completed filled in by the funeral director, page 2	Medical	(Check 2 ☐ Med	rtifying Physician: To the best of edical Examiner: On the basis of edical Examiner:	kamination and/or in	vestigation, in my opinion, death	occurred at the time, date a	nd place, and due to the c	ause(s) and manner stated.		
o the	within 2 To the comple		only one) 3 Cert 29b. Signature and title of ce	rtifying Nurse Practioner: To the	best of my knowled	ge, death occurred at the time, d	ate and place, and due to the	e cause(s) and manner as s 29d. Date signed (Month,	stated.		
	> F 0		Dules	refrent		P5069.		March 1			
	5		30. Name and address of pe	person who completed cause of de							
	Stat	e	31. Date filed (Month, Day, +	() Feb, 0/4 / A	up Sin	A	of Balhons				
	Registra		MAR 2	2 0 2012 Setus		are					
ПНМН	17 Rev 7/20	00		7	- 1						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Phongsak Boonsri Physician/ 16, 2012 March 11:12 AM Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death
Baltimore 4b. City, Town, or Location of Death Examiner Baltimore 8314 Streamwood Drive If Under 1 Year If Under 24 Hrs. Social Security Number 7. Age (In vrs. last birthday) 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** Days Hours Min November 7. Director 219-15-8437 1**XX**M 2 □ F 56 Thailand 1955 show at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director must be notified Baltimore 28a-f Maryland Baltimore 1 Yes 2XXNo 10e. Street and Number 10f. Zip Code ö 10g. Citizen of What Country?
United States 21208 23a Funeral 8314 Streamwood Drive of America items death 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2X No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Examiner Black, White, etc. 0 þ 1 Never Married 2XXMarried Baltimore, Maryland 21215-0036 filed within 72 hours after 1 Yes 2XNo Specify. Thai Specify: "natural", 3 Widowed 4 Divorced Completed Year or Dates Medical 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Il Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) the Construction Demolition other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) nd Mental F မ Thongliam Fannin Page 1 and 2 should be Khongsap Boonsri is me 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) of Health a Robert Gatta/ bro.-in-law 1819 Wilson Point Rd. Middle River, Maryland 21220 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Evans Funeral March 20, = ō 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Important: It any injury or Forest Hill, Maryland 4 Donation 5 Other (Specify) 2012 Chapel- Bel Air Signature of Fune al Service Licensee Peaceful Afternatives Funeral and Cremation Center, P.A. 2325 York Road Timonium, Maryland 21093 23a. Part 1. Effer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final ANCE Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** quantially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) burial-trar that initiated events resulting in death) Last Due to (or as a consequence of) attending physician Physician/Medical P.O. Box 68760 the as IF FEMALE: JSe 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery ☐ Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Dav Year Pregnant at time of death 5 Other (specify) signed by the a 1 Yes 2 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Emphysema Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown page 2 should peen 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed Yes 2 has After this certificate 25. Was case referred to medical examiner? Hospital or Attending Physician: 24 hours after death. Funeral Director: After this certific 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: မ 1 🗌 Yes 2 XNo 1 Inpatient 2 ER/Outpatient 3 DOA completely filled in by the funeral 28a. Date of injury (Month, Day, Year) Manner of Death 28b. Time of Certificate: 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred 1 Natural injury 5 Pending Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check

Registrar

within 2

3 🗆

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29b. Signature and title of certifier

only one)

DHMH 17 Rev 06-2011

29c. License number

29d. Date signed (Month, Day, Year)

1614 WILKENS AVE. BALT, MO 21223

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Physician/ Virginia Rose Bowen 812 A M 2012 Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number, 4b. City. Town, or Location of Death Examiner Rosedale Baltimore FRANKLIN SQUARE Hospital 5. Social Security Number 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) If Under 9. Birthplace (State or Foreign **Funeral** Days Hours Min. 219-07-1601 **Director** 1 □ M 2 💢 F Baltimore, MD 92 Yrs. July 13, 1919 Usual Residence of Decedent 28a-f show 10c. City, Town or Location 10d. Inside City Limits 10a. State the Maryland notified at Director Harford MD Abingdon 1 Yes 2 X No 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? ms 23a or must be Funeral with 339 Sullivan Drive 21009 United States items 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12 Was Decedent Ever in U.S. 14 Race - American Indian 11. Marital Status Armed Forces?

1 Yes 2 X No Examiner Black, White, etc. ō þ 1 Never Married 2 Married 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 ☐ No Specify: White "natural" Completed 3 X Widowed 4 □ Divorced ULFGIN the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Administration Elementary/Secondary (0-12) College (1-4 or 5+) 12 Secretary ulth and Mental Hygie 27 is marked other r traumatic event, t Be Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Maurice Chronister Christianna Ripper t. Page 1 and 2 should be tment of Health and Men rant: If item 27 is marke 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Judith Glennon-Daughter 339 Sullivan Drive Abingdon, MD 21009 permit. Page 1 and 2 Department of Health Important: If item 27 any injury or other t. Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State March 21 Evans Funeral 1 Burial 2X Cremation 3 Removal from State Forest Hill, 4 Donation 5 Other (Specify) 2012 -Bal Air 22. Name and Address of Facility
Evans Funeral Chapel & Cremation Services
8800 Harford Rd. Parkville, MD 21234 Signa 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death mmediate Cause (Final Physician ocardial In Farction Myocardial
Due to (or as a consequence of) disease or condition Medical resulting in death) **Examiner** pheumonio Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examine ue to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed the burial-transi and Due to (or as a consequence of) attending physician for use as the buria Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Pregnant at time of death 5 Other (specify) Day been signed by the a should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsv After this certificate has funeral director, page 2 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) P 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA within 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral di 28a. Date of injury (Month, Day, Year) 27, Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred 1 Natural injury 5 Pending Investigation Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Under the cause of the cause (Check only one)

Registrar

9000 FRANKLIN SQUARE DR Balto Md DRhelia Sanch E 32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29b. Signature and title of certifier

29c. License number

DO067697

29d. Date signed (Month, Day, Year) 112

21237

03/18

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Physician/ NNIE Medical 4a. Facility Name (if not institution, give street and number) Town, or Location of Death **Examiner** 4c. County of Death
Balfindre Seasons andallstown Hospice & Northwest Social Security Number If Under 1 Year If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Birthplace (State or Foreign Country) 220.24.0995 Months Min Director 1 M 2 X F 80 05 02 Usual Residence of Decedent 28a-f shov 10a. State 10b. County 10c. City, Town or Location notified at 10d. Inside City Limits Director MD Baltimore Baltimore 1 Yes 2 No 10e. Street and Number 10f. Zip Code 'n 10g. Citizen of What Country? must be Funeral 23a Court USA within 72 hours after death 11. Marital Status 12 Was Decedent Ever in LLS 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, th and Mental Hygiene. 27 is marked other than "natural", or iter traumatic event, the Medical Examiner Armed Forces?

1 Yes 2 No
If Yes, Give Black, White, etc þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify. Black 3 Divorced Specify: Completed Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Self-Employed Entrepreneur 12th grade NIA 1 and 2 should be filed w of Health and Mental Hygistiem 27 is marked other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည ROY B. Council BIONN Lou 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Old Battonore MD Daughter Bova M Koad Place of Disposition proceeding or other place, cemetery, crematory or other place, cemetery, cemetery 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State Page 1 permit. Page 1
Department of Important: If it any injury or o 1 Burial 2 Cremation 3 Removal from State Woodlawn, MD 2012 4 ☐ Donation 5 ☐ Other (Specify) 03 Noodlawn Greene Puneral Services 21. Signature of Funeral Service Licenses 22. Name and Address of Facility aughn Jaux Koad & andallstown disease, or complications that caused the death. Do not enter the mode of dying, failure. List only one cause on each line. 23a. Part 1 nter th Approximate Interval Between Onset and Death Immediate Casco (Final angre ae disease or condition Medical resulting in death) Examiner Sequentially list conditions, it any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of and -tran or Attending Physician; The law requires that the death certificate be execu Due to (or as a consequence of): burial-1 the attending physician Physician/Medical Box 68760 as the IF FEMALE: nse 23c. If ves, outcome of pregnancy 23b. Was decedent pregnan 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ Live Birth 2 Fetal death in the past 12 month Month Day Year Pregnant at time of death detached 9 Unknown P.O. þ been signed be should be det Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an this certificate has rail director, page 2: autopsy death? Yes 2 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? hou 2 No ဂ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 27. Mann 28a. Date of injury (Month, Day, Year) Certificate: f Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director; After completely filled in by the funer Natural 5 Pending 1 🔲 Yes 2 🗆 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Hospital Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a Certifie (Check only one 29b. Signature and title of certifie Date signed (Month, Day, Year 30. Name and address npleted cause of death (Item QCB 3 ate filed (Month, Day, Year) State Registrar

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hydiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death Physician/ JAMES BURCH BROOKS, M.D. Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death N/A4b. City, Town, or Location of Death Examiner Union Memorial Hospital Baltimore City If Under 1 Year I If Under 24 Hrs. Social Security Number 7. Age (In yrs. last birthday, **Funeral** 9. Birthplace (State or Foreign Hours (Month, Day, Year) 215-34-7060 Director 1 💢 M 2 🗌 F 85 Jul 1, 1926 Maryland Usual Residence of Decedent an "natural", or items 23a or 28a-f show Medical Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director N/A Maryland Baltimore City 1 X Yes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 111 Hamlet Hill Road, #604 21210 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 Never Married 2 X Married ρ 1 X Yes 2 ☐ No If Yes, Give Maryland 21215-0036 WWII 1 ☐ Yes 2 X No Specify: 3 Widowed 4 Divorced Completed White Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) and Mental Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) the Medical Services <u>Physician</u> 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) James Vincent Brooks, Jr. Burch Loretto 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ge 1 and 2 st of Health a : If item 27 is 111 Hamlet Hill Road, #604, Baltimore, MD 21210 Laetitia Martin Brooks (Wife) Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) permit. Page 1 a
Department of H
Important: If ite
any injury or ot Date 20c. Location - City or Town, State 1 🗌 Burial 2 💢 Cremation 3 🗀 Removal from State Green Mount Crematory 3/20/2012 4 ☐ Donation 5 ☐ Other (Specify) |Baltimore, Maryland 21. Signature of Eune of Service Company MTTCHELL WIEDEFELD FUNERAL HOME, INC 6500 York Road, Baltimore, Maryland Martin D. Lawson 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ Pulmonog abstructive disease or condition CHROZIC Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Liner Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Exami and -tran Due to (or as a consequence of) resulting in death) Last Physician/Medical that the death certificate be Box 68760 IF FEMALE: use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months? Month Pregnant at time of death 5 Other (specify) Day Year Yes 2 No 9 Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, Completed 1 Tes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy performe Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 1 No မ 1 ☐ Inpatient 2 ☑ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work?
1 ☐ Yes Certificate: 28d. Describe how injury occurred 1 Natural 5 Pending 2 🗌 No Accident Investigation 24 hours after deat Funeral Director: Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 28f. Location (Street and Number or Rural Route Number, City or Town, State) Hospital Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier To the Hosp within 24 ho To the Fune completely f Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29c. License number 29d. Date signed (Month, Day, Year, 3/18/12 00054056 2 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) LOWST BEIT WO 21211 702 GOST State MAR 2 0 2012 Registrar

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month March Physician/ Butler 2012 George 15 14:08 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner PG Clinton Southern MD Hospital 5. Social Security Number If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday **Funeral** Days Hours 09-12-1943 227-56-4137 **Director** 1 **X** M 2 \square F 68 North Carolina Usual Residence of Decedent 28a-f show 10d. Inside City Limits Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or items 23a or 28a-f show 10c. City, Town or Location 10a. State 10b. County must be notified at Director 1 X Yes 2 No MD Clinton PG 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Funeral 20735 USA 7603 Mulligan Ln. "natural", or items edical Examiner mu Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. 11. Marital Status Armed Force Black, White, etc. 1 ☐ Yes 2 X No If Yes, Give Year or Dates. Completed by 1 Never Married 2X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2🌠 No Specify. Specify: White 3 Widowed 4 Divorced traumatic event, the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Dockman Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ၉ Butler Odell White George 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7603 Mulligan Ln. Clinton, MD 20735 Tina Butler/Wife other 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Department of H Important: If ite any injury or ot 1 ☐ Burial 2XI Cremation 3 ☐ Removal from State Riverdale Park Crem. 3-26-2012 Riverdale, MD 4 Donation 5 Other (Specify) Dermit. Signature of Funeral Service Licenses 22. Name and Address of Facility Ronald Taylor II FH 10583 Middleport Ln. WHite Plains, MD 20695 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on, Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or Examiner Sequentially list conditions. if any, leading to immediate cause. Enter Underlying Exami To the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or injury attending physician and I for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Year Pregnant at time of death 5 Other (specify) 4 ☐ Pregnant 9 ☐ Unknown been signed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an page 2 s autopsy perform 1 Yes 2 No After this certificate 2 filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be 1 Yes 2 No Certificate: To 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 1 Natural 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred injury 5 Pending s after death. Accident
Suicide Investigation Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined within 24 hours a

To the Funeral C Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar

· In

1328 Southern

D0055120

Avenue SE Sute 310 Washington De

(m)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death March 17 Day 2012 Year Physician/ РМ Blumenschein Randall 4:20 James Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death Examiner 4c. County of Death Shady Grove Adventist Hospital Montgomery Rockville If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) 8. Date of Birth **Funeral** Months Days Hours Min November 14, 1951 North Carolina 228-74-8766 Director 60 Usual Residence of Decedent 28a-f show 10b. County with the Maryland must be notified at 10a State 10c City Town or Location 10d. Inside City Limits Director 1 Yes 2 X No Gaithersburg Maryland Montgomery 10e. Street and Number 10f. Zip Code ò 10g. Citizen of What Country? Funeral items 23a 20878 United States 12304 Morning Light Terrace death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian the Medical Examiner Armed Forces? Black, White, etc. ō 1 Never Married 2 X Married ģ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates Specify: "natural", Completed 3 Widowed 4 Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Federal Government al Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Department of Commerce Chief Financial Officer 4 Blumenschein other traumatic event. Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental Fis marked o ဂ Billie Way James Eugene Blumenschein 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health a 12304 Morning Light Terrace, Gaithersburg, Maryland 20878 Nancy L. Blumenschein/Wife Department of Healt Important: If item 2 any injury or other t 20a Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 XBurial 2 Cremation 3 Removal from State cemetery, crematory or other place) March 23, 2012 Germantown, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Souls Cemetery 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Robert A. Pumphrey Funeral Home/Rockville, Inc. 300 West Montgomery Avenue, Rockville, Maryland 20850–2805 The Three M01360 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. nterval Between Immediate Cause (Final Onset and Death Physician/ Cardio Due to (or as a confequence of): disease or condition Medical resulting in death) Examiner Sh Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine r as a consequence of -transit oration and Due to (or as a consequence of): resulting in death) Last burial physician a the burial-Physician/Medical Box 68760 nding p IF FEMALE: nse 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ atten in the past 12 months? for Year Month Day Pregnant at time of death signed by the a Yes 2 No Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Onknown Completed page 2 should peen 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy performed? death? this certificate 2 🗌 No Yes 25. Was case referred to medica Be 26. Place of Death (Check only one) examiner?
1 Yes 2 No Hospital Other: 잍 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 5 Pending work? 1 Natural 2 🗌 No ☐ Accident ☐ Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier

P.O. 1 Division of Vital Records, To the Hospital or Attending Physician; within 24 hours after death.

To the Funeral Director. After this certifics completed filled in by the funeral director, to

3/17/2012

Cheng Fer 9901 mo 31. Date filed (Month State MAR 2 0 2012 Registrar DHMH 17 Rev 7/2009

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

(Check

29b. Signature and title of certifier

32. Registrar's Signature

9 m.

3 Certifying Nurse Practioner. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

medical

D 0065505

29d. Date signed (Month, Day, Year)

March 18, 2012

Rockville MD 20850

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #205 Per FH 6926 4/05/2012 JH. State of Maryland / Department of Health and Mental Hygiene - State Registrar Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 537 AM Physician/ Month Year clrin March 2012 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Batimore 8. Date of Birth Johns Hopkins HOSPITAL Birthplace (State or Foreign Country)
 SC 7. Age (In yrs. last birthday) 78 If Under 1 Year If Under 24 Hrs. **Funeral** 11-26-1933 249-46-5015 Days **Director** 1 🛛 M 2 🗆 F Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must he notified at 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits **Funeral Director** MD Baltimore 1 ¥ Yes 2 □ No 10f. Zip Code 21213 10e. Street and Number 10g. Citizen of What Country? 1119 Kenwood Avenue USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc þ 1 Never Married 2 Married 1 ¥ Yes 2 ☐ No If Yes, Give Baltimore, Maryland 21215-0036 Specify: Black 1 ☐ Yes 2 X No Specify. Completed 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Bethlehem Steel Elementary/Secondary (0-12) College (1-4 or 5+) Steel Worker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) UVH ၉ Adam Brown 19a. Informant's Name/Relationship (Type, Print) Wife 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Gladys P. Brown 1119 Kenwood Ave. Balto MD 21213 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other p 03/30/2012 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State Garrison ForestCem 3-23-2012 Owings Mills MD 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Licensee 22. Name and Address of Facility Phillip A Weatherford FS PA 2431 E Oliver St Balto MD 21213 Balto MD 21213 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ Due to (or as a Insequence oil: Arres disease or condition resulting in death) Medical Examiner Arcuthuia Sequentially list conditions, Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury ue to r as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed -tran and that initiated events resulting in death) Last Due to (or as a consequence of) the burial After this certificate has been signed by the attending physician Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 as IF FEMALE: for use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Day Year Pregnant at time of death 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? page 2 should be 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No Yes 2 No completely filled in by the funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Yes 2 No Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify, 28c. Injury at work? Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28d. Describe how injury occurred injury Natural 5 Pending 1 Yes 2 No 2 Accident M Investigation **Director:** 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) To the Hospital within 24 hours a To the Funeral D Medical 29a. Certifier certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Res-000 March 15, 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 400 Yorth jork Wolfe Street Baltimore mo 21287 31. Date filed (Month, Day, 82. Registrar's Signature (ear) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 2. Date of Death 3. Time of Death Day Physician/ 03 2012 25 Vernice Cherry Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Gilchirst Hospice Towson Baltimore 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday **Funeral** (Month, Day, Year) Months Days Hours Director 231-84-9058 57 03 17 54 ٧A Usual Residence of Decedent 28a-f show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygene. Important: If tiem 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event, the Medical Examiner must be notified at 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 ☐ No MD NA Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1943 West Lafayette Ave 21217 U.S.A. 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married ð Yes 2X No Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Specify: Black 3 X Widowed 4 ☐ Divorced Completed Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Dept. of Elementary/Secondary (0-12) College (1-4 or 5+) 12th grade Transportation Security Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ge 1 and 2 should be filed nt of Health and Mental Hy :: If item 27 is marked oth Johnny Cherry Norella Mary E. Pannell 19a. Informant's Name/Relationship (*Type, Print*) Daughter 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1943 West Lafayette Ave, Baltimore, Md Latania Darlene Wesley 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Page 1 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State King Memorial Park 3/19/2012 Woodlawn, Md 4 Donation 5 Other (Specify) ture of Funeral Service Licensee 21, Sign 22. Name and Address of Facility March F/H West 4300 Wabash Ave, Baltimore, Md 23a. Par 1. Enter the of lease, or complications that use the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart fill re. List only one cause on each line. Approximate Interval Between Onset and Death Physician/ mult disease or condition resulting in death) 10 Le =125 Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Exam that the death certificate be executed Cause (Disease or injury nding physician and use as the burial-trar that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ___ in the past 12 months?

1 Yes 2 No Month Day Year Pregnant at time of death signed by the 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 🗌 Yes No 3 Probably 4 Unknown Completed should peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy performed certificate 2 🗌 No 1 🗌 Yes the Hospital or Attending Physician; funeral director, Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence Other (Specify) WOSDILE 2 No 1 🗌 Yes မ 1 Inpatient 2 ER/Outpatient 3 DOA this 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of Injury at 28d. Describe how injury occurred Director: After 1 Natural 5 Pending after death. 1 ☐ Yes 2 ☐ No Accident
Suicide Investigation filled in by the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined hours Funeral Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 24 (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated within 2 To the ense number 29d. Date signed (Month, Day, Year)

Registrar

DHMH 17 Rev 06-2011

State

31. Date filed (Month, Day,

Q

601

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First Middle Last 2. Date of Death 3. Time of Death Month Physician/ May A. Caldwell March 2012 50A Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Baltimore Timonium Stella Maris Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Hours Min 212-01-7673 **Director** 1 M 2XXF 95 Yrs. Maryland March 15, 1917 28a-f show with the Maryland injury or other traumatic event, the Medical Examiner must be notified at 10a, State 10c. City, Town or Location 10d. Inside City Limits Director Maryland Harford Forest Hill 1 🗆 Yes 2 🍱 No 10e. Street and Number 10f. Zip Code . Citizen of What Country? **United States** Funeral 23a 202 Kimary Ct. #3A 21050 of America items 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 🍱 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. ŏ þ 1 Never Married 2 Married within 72 hours after white If Yes, Give Year or Dates 1 ☐ Yes 2 🔀 No Specify: Completed Specify: "natural" 3℃Widowed 4 □ Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working than life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Homemaker Residence 12 other Be Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental is marked 2 pe Raymond Royal Adams Sadie Catherine Wilson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health an Important: If item 27 is 1 any injury or other traum Raymond R. Blank/ nephew 202 Kimary Ct. #3A Forest Hill, Maryland 21050 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State ch 20 moreland, Memorial Park 1 🔀 Burial 2 🗌 Cremation 3 🔲 Removal from State 2012 Parkville, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Mineral Service License Peaceful Alternatives Funeral and Cremation Center, P.A. 9 2325 York Road Timonium, Maryland 21093 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Ph, sician/ neumon disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions, Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of). the burial-trar that initiated events Due to (or as a consequence of): resulting in death) Last physician Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant in the past 12 months?
1 Yes No
9 Unknown 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ Day Pregnant at time of death ☐ Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably Unknown Division of Vital Records, 24b. Were autopsy findings available 24a. Was an After this certificate has autopsy prior to completion of cause of death? 1 Yes 2 No __ Yes the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital Other: 2 X No မှ 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 5 Residence Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred work? Natural injury 5 Pending ☐ Accident Investigation Director; 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined within 24 hours a

To the Funeral D Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 X Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and b 29c. License number 29d. Date signed (Month, 30. Name and address of person who complete clause of death (Item 23a) (Type, Print) Q TIMONIUM 21093 CRNP 2300 DULANEY VALLEY ROAD MD TRACIE MORGAN,

Registrar

DHMH 17 Rev 06-2011

State

CALDWELL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2 Date of Death Day 2012 March 17 6:27 P M John Richard Cox 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Frederick Ballenger Creek 6258 Derby Drive If Under 1 Year If Under 24 Hrs. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Hours Jan 23, Months 490-34-2977 1937 1 **X** M 2 □ F 75 Missouri Usual Residence of Decede 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No Frederick Ballenger Creek 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6258 Derby Drive 21703 USA 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces? Black, White, etc. 1 Never Married 2X Married 2 No If Yes, Give Year or Dates. 1957–60 1 Yes 2X No Specify: Specify: White 3 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 12 Audio Visual Specialist Federal Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Albert Wilson Cox Dorothy Putthoff 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Susan Cox/wife 6258 Derby Drive Ballenger Creek, MD 21703 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 Burial 2X Cremation 3 Removal from State Final Journey Crematory 03/20/12 4 ☐ Donation 5 ☐ Other (Specify) Woodbine, MD 22. Name and Address of Facility
Going Home Cremation Service P.O. Box 784
MO1251 Beverly L. Heckrotte, P.A. Clarksville, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final a Metastatic Stage IV Lung Cancer Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of) 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) ___ Month Day Year Pregnant at time of death Unknown 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 🔀 No 3 ☐ Probably 4 ☐ Unknown

24b. Were autopsy findings available prior to completion of cause of death?

1 Yes

29d. Date signed (Month, Day, Year)

March 19, 2012

2 🗌 No

Ph_sician/ Medical **Examiner**

Department of H Important: If ite any injury or ot once,

Physician/

Examiner

Funeral

Director

show at

ō

ems 23a or r must be r

the Medical Examiner

items death

ō

"natural"

al Hygiene.

of Health and Mental Hoftem 27 is marked of them traumatic ever

Maryland 21215-0036

Baltimore,

Page 1

within 72 hours after

notified 28a-f

Medical

Director

Funeral

ò

Completed

Be

2

MD

Examine use as the burial-transit attending physician been signed by the s should be detached

law requires that the death certificate be

Box 68760

P.O.

Records,

Division of Vital

Physician/Medical þ Completed eral Director: After this certificate has filled in by the funeral director, page 2 Hospital or Attending Physician: The I.
 Hours after death.
 Funeral Director: After this certificate h Be ဨ Certificate:

To the Hosp within 24 hor To the Fune completely f Yo Registrar

Medical

29a. Certifier

disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Liner Underlying Cause (Disease or injury that initiated events resulting in death) Last 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Hypertension, Hepatitis 24a. Was an performed? Yes 2 X No 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 X Residence 6 Other (Specify) 1 Yes 2 X No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1X Natural 5 Pending work? 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Sadaf Taimur, M.D. 46-B Thomas Johnson Drive Frederick, MD 21704

. Date filed (Month, Day, Year) MAR 2 0 2012

29b. Signature and title of certi-

32. Registrar's Signature A. Sails

1 💢 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29c. License number

D61961

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			For State		State of	Marylan		artment of H		and N	-	_	001	0	00500				
			Registrar 1. Decedent's Name	(First. Middle.	Last)		Cer	tificate of D	eatn		2. Date of De	Reg. No. 3. Time of Death							
	Physicia				nilds						Month	Day Year							
,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	Medio Examin	_	4a. Facility Name (if n	ot institution,	give street and numbe	er)		4b. City, Town, or	Location	of Death	ridicii		. County of De	ath	0003				
أكمعرب			Kline Hos					Mt Airy					rederio						
	Funeral Director		5. Social Security Nur 212–36–63 Usual Residence of	49	5. Sex 1 X M 2 □ F	Age (In yrs. I		If Under 1 Year Months Days	If Under Hours	Min.	8. Date of Birl (Month, Da Jan 18	y, Year)	C	country	ce (State or Foreign Virginia				
	and show	ρ		10b. County		10c. Cit	y, Town or Lo	cation						100	d. Inside City Limits				
	Maryl 28a-f otifie	Director	MD :	Freder:	ick	Kno	xville								1 Yes 2 No				
	th the		10e. Street and Numl					10f. Zip Code					tizen of What C	Countr	y?				
	ath wi	Funeral	210 Jeffe	rson P	12. Was Decede	nt Ever in II s	S 113 V	21758 Vas Decedent of His	snanic Ori	igin? (Spe	cify Yes or No-	USA	14. Race - Am	aericar	Indian				
21215-0036	72 hours after death with the Maryland n "natural", or items 23a or 28a-f show ledical Examiner must be notified at	þ	1 Never Marrie		Armed Force	es? E x No	1	f Yes, specify Cubar	n, Mexicar	n, Puerto	Rican, etc.)		Black, Wh						
5-0	"natu dical	Completed	(Spec	15. Decedent	's Education t grade completed)		16a. Deced	lent's Usual Occupa kind of work done d	ation	t of worki	na	16b, K	6b. Kind of Business/Industry						
121	within 72 giene. her than t, the Me	mo	Elementary/Secor		College (1-4	or 5+)	life. D	O NOT use retired)	aring moo		ng .								
Q 2	filed within al Hygiene.	Bec	12 17. Father's Name (Fi	irst. Middle. La	lst)		Brick	layer	18 Moth	er's Name	e (First, Middle,		structi	LON					
an	be fillental	၉	Alva Gay		,						May Gi		,						
Maryland	permit. Page 1 and 2 should be filed within 72 hour Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturany injury or other traumatic event, the Medical once.		19a. Informant's Nar Tammy Ger		p (Type, Print) POA/Friend			ng Address (Street a						e, Zip Code)					
Baltimore,			20a. Method of Dispo		3 ☐ Removal from St		Place of Dispo	sition (Name of natory or other place	e)	(Date	20c. Lo	ocation - City o	or Tow	n, State				
ţi			4 Donation			" Fin	al Jou	rney Crem	ator				dbine,						
Bal	permit Depar Impor any in		21. Signatur of Fund	y L	belitte	МО	c ²² 1251Be	Name and Addressing Home verly L.	s of Facili Crema Heck	ation	n Service, P.A.	ce Cla	P.O. Borksvill	ox le,	784 MD 21029				
P			shock, or heart	failure. List or	complications that cau ly one cause on each	sed the deat line.	h. Do not ente	er the mode of dying	g, such as	cardiac c	r respiratory ar	rest,		1	Approximate Interval Between Onset and Death				
-	Physician/ Medical		Immediate Cause (F disease or condition resulting in death)		a. Squamor	us cel	1 Cano	er of Lun	g Wi	th bi	ain Me	tast	asis	1	month				
Sept.	Examiner	Ш		- 1	ue to (or	as a consequ	uence or):												
	ate be executed physician and the burial-transit	iner	Sequentially list con If any, leading to in- cause, Enter Underly	ditions,	b. Justo for	as a consequ	liante oi):												
		Examiner	Cause (Disease or in that initiated events	njury	C								\perp						
_	ate be executed by sician and the burial-trans	al E	resulting in death) La	451	Due to (or	as a consequ	uerice oi).												
260	physis the	ledical			d														
Box 68760	certifi ending use a	an/N	IF FEMALE: 23b. Was decedent p		23c. If yes, outco			Ectopic pregnanc	· ·			1,,	23d. Date of d	delivery	,				
). Bo	nat the death certific ed by the attending p detached for use as	Physician/M	in the past 12 m 1 Yes 2 U 9 Unknown	No		nt at time of o		Other (specify)	y 			Month Day Year							
P.O.	s that gned b				ns contributing to dear	th but not res	sulting in the u	inderlying cause giv	en in Part	1.					cause of death?				
rds,	requires that been signed should be det	sted	Stroke, D	ementia	1,						1 🗆	Yes 2	X No 3 □	Proba	bly 4 🗌 Unknown				
of Vital Records,	has by	Completed by		· ·							24a. Was autop		24b. Were a prior to death?	o com	y findings available pletion of cause of				
Ä	sician: The law is certificate has build irector, page 2 s		25. Was case referred	to medical				26 Pla	ace of Dea	th /Charl	1 🗌 Yes				□ No				
Vita	ysicia s certi direct	To Be	examiner? 1 \square Yes 2 \boldsymbol{X}		Hospital:	patient 2 🗆	ER/Outpatier	Tothe	ad:		me 5 Resid	dence 6	XOther (Spe	acify)	hospice				
on of	Attending Physician: The law requires that the death certific ardeath. After this certificate has been signed by the attending by the funeral director, page 2 should be detached for use as	Certificate: 1	27. Manner of Death 1 Natural 2 Accident	5 Pending	28a. Date of (Month,		28b. Time of injury	28c. Injury work	at		28d. Describe h			50.197_					
Division	l or Atte after de Directo d in by th	Certif	3 ☐ Suicide 4 ☐ Homicide	6 Could n	28e. Place of	Injury - At ho etc. (Specify		eet, factory, office			28f. Location (S City or Tow			Rural R	oute Number,				
۵	To the Hospital or Attenc within 24 hours after deatl To the Funeral Director: , completely filled in by the	Medical	(Check 2	Medical Ex	Physician: To the best aminer: On the basis Nurse Practitioner: To	of examination	n and/or invest	tigation, in my opinio	n, death o	ccurred at	the time, date a	and place	, and due to the	e caus	e(s) and manner stated.				
•	To the within 2 To the comple		29b. Signature and ti		Om			29c. License D37337	number				te signed (Mor		y, Year)				
	3m		30. Name and address	ss of person w	ho completed cause of	of death (Item	n 23a) (Type, P	Print)											
	20.		Naveen Do	ki, M.I	. 46B Thor			Dr. Frede	rick,	. MD	21702								
	Sta Registra		31. Date filed (Month, MAR 2)	Day, Year) 0 2012	32. Reg	istrar's Signa													

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death March 14, Physician/ 201Ž 9:00pm Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Carrol1 Sykesville 394 Ronsdale Road If Under 1 Year I If Under 24 Hrs. 9, Birthplace (State or Foreign Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** Months Hours Jan. 11, Year) 1941 1 🛣 M 2 🗆 F Days OH 71 Yrs Director 283-36-0015 Usual Residence of Decedent 28a-f shov 10d, Inside City Limits 10b. Count 10c. City, Town or Location permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at once. Director 1 ☐ Yes 2X No Sykesville Carroll 10f. Zip Code 10g. Citizen of What Country? 10e, Street and Number Funeral USA 21784 394 Ronsdale Road Was Decedent Ever in U.S. Armed Forces? 1▲ Yes 2 □ No Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 1 Yes 2 No Specify If Yes, Give 1959-80 Specify: White Completed 3 Divorced 4 Divorced Year or Dates. 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business Industry (Give kind of work done during most of working life, DO NOT use retired) (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) Master Chief Retired US Navy Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Emma Alice Murray Henry Robert Coy 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 394 Ronsdale Road, Sykesville, MD 21784 Mrs. Wanda J. Coy (Spouse) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) All County Cremation 3/16/2012 Sykesville, MD 21. Signature of Funeral Service Licenses 22. Name and Address of Facility HAIGHT FUNERAL HOME & CHAPEL, PA PO Box 195 Sykesville, MD 21784 pouan MO0763 trug 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical **Examiner** Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burlal-trans that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy
☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 5 Other (specify) Month in the past 12 months? Day Year Pregnant at time of death 1 Yes 2 g Yes 2 No g 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 2 No 3 Probably 4 Unknown 1 Yes 24b, Were autopsy findings available 24a. Was an prior to completion of cause of death? page 2 s autopsy performed 1 Yes 2 No the funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 2 No မ 1 🗌 Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: After injury work? 1 Natural 5 Pending Investigation Accident within 24 hours after death

To the Funeral Director: / 6 Could not be Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Hospital Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated rectioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: Certifying Nurse only one) d title of certifier 29d. Date signed (Month, Day, Year) 29b. Signature

DHMH 17 Rev 7/2009

State Registrar 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 🤈 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death March 18, 2012 Year Physician/ 9:17 Ам Nancy C. Curley Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Montgomery Rockville 614 Monroe Street If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Hours Director 198-16-3583 1 M 2 X F October 1,1925 Usual Residence of Deceden Pennsylvania 86 show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits at **Funeral Director** notified 28a-f 1 🗌 Yes 2 💢 No Maryland Montgomery Silver Spring 0 10f. Zip Code 10g. Citizen of What Country? pe 23a must b 11510 College View Drive 20902 United States items permit. Page 1 and 2 should be filed within 72 hours after death \
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items any injury or other traumatic event, the Medical Examiner muonee. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married 1 ☐ Yes 2 💢 No If Yes, Give 1 Yes 2 X No Specify: Specify: Completed 3 X Widowed 4 Divorced White Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) College Secretary Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) မ Mary Jane Shira Donald Christie 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 17120 Butler Road, Poolesville, Maryland 20837 Donald D. Farr/ Son 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State March 26, 2012 4 ☐ Donation 5 ☐ Other (Specify) Butler, Pennsylvania Northside Cemetery 22. Name and Address of Facility Robert A. Pumphrey Funeral Home/Rockville, Inc. 300 West Montgomery Avenue Rockville, Maryland 20850-2805 21. Signature of F Service Lice м00335 23a. Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ Immediate Myocardial Infarction disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Coronary Artery Diseas Sequentially list conditions, Examine cause. Enter Underlying Cause (Disease or injury that initiated events onsultilend Due to (or as a consequence of): resulting in death) Last burial-Physician/Medical guipt IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year Pregnant at time of death Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed Cardiomegaly, Pacemaker for Arrhythmia 1 X Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Valvular Disorder has le 2 autopsy page 2 🗆 No Yes 2 X No 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 X Other (Specify) Home 은 1 X Yes 2 □ No 1 Inpatient 2 ER/Outpatient 3 DOA Certificate: 27. Manner of Death 28b. Time of

Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 n 24 hours after uccom... ne Funeral Director: After the netely filled in by the funera

the Maryland

with

Baltimore, Maryland 21215-0036

28a. Date of injury (Month, Day, Year) 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred 1 X Natural 5 Pending Investigation Accident
Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined

29a. Certifier X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number

Do2338

March 19, 2012

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

3929 Ferrara Drive, Wheaton, Maryland 20906 Richard P. Delaney, M.D.

State Registrar

Medical

31. Date filed (Month, Day, Year) 32. Registrar's Signatu MAR 2 0 2012

within 2 To the F

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 214 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City. Town, or Location of Death 4c. County of Death Anne Arundel Harwood Mandarin Care Center If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign **Funeral** Days 213-26-1656 **Director** 1 □ M 2 🗓 F Yrs 80 07/07/1931 PA Usual Residence of Decede shov 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits with the Maryland **Funeral Director** ems 23a or 28a-f sh r must be notified a MD Gambrills 1 ☐ Yes 2 💢 No Anne Arundel 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 21054 2610 Chapel Lake Drive, Unit 109 U.S.A. Page 1 and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Examiner Black, White, etc. 0 by 1 Never Married 2 Married 1 ☐ Yes 2 🏋 No If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛣 No Specify: White "natural" 3 XWidowed 4 ☐ Divorced Specify Completed Year or Dates Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Il Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) the Nurse **Healthcare** event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Department of Health and Mental I Important: If Item 27 is marked o any injury or other traumatic eve once. မ Zylak Pau1 Stihel Lucy 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 110 Wye Knot Court Queenstown, MD Mrs. Cheryl Meyers / Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 🔀 Burial 2 □ Cremation 3 □ Removal from State cemetery, crematory or other place) Glen Haven Mem. Park |03/19/2012 Glen Burnie, MD 4 ☐ Donation 5 ☐ Other (Specify) MO1479 22. Name and Address of Facility 1 2nd Avenue SW Glen Burnie, MD Singleton Funeral & Cremation Services, PA 23a. Part 1. Enter the disease, or complications that caused the death shock, or heart failure. List only one cause on each line. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Exami for use as the burial-tran and Due to (or as a consequence of) nding physician Physician/Medical the Hospital or Attending Physician: The law requires that the death certificate behaves after death.

the Funeral Director: After this certificate has been signed by the attending physicia Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?
1 Yes 2 No 5 Other (specify) Pregnant at time of death Month Year Day detached signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Completed by 1 🗌 Yes 2 No 3 ☐ Probably 4 ☐ Unknown director, page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 🗆 Yes 2 🗆 No Yes 2 Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? ALANDRIN INP Other: 4 Nursing Home 5 Residence 6 မ 1 Yes 2 ANO 1 Inpatient 2 ER/Outpatient 3 DOA filled in by the funeral 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at work? 1 ☐ Yes 2 ☐ No 1 Natural 28d. Describe how injury occurred 5 Pending Accident Investigation ☐ Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) within To the 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day Year)

crost

32. Registra

2018

DITH

Amapol

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year Month Physician/ ELSIE CORNISH 9:20 AM March 2012 Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death **Examiner** of Baltimore Baltimore Sinai Hospital Social Security Number If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** Hours Min (Month, Day, Year) 217-24-3083 Director 1 M 2 F Yrs. 7-12-1927 MARYLAND 84 Usual Residence of Decedent or 28a-f shov 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ed other than "natural", or items 23a or 28a-f sho event, the Medical Examiner must be notified at Director with the Maryland 1 X Yes 2 No MD. BALTIMORE GWYNN OAK 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 2820 ARLENE CIRCLE 21207 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1. Marital Status 12 Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces? Black, White, etc. 1 Never Married 2 Married þ Maryland 21215-0036 1 ☐ Yes 2 No Specify: If Yes, Give Year or Dates Specify: BLACK Completed 3 ₩idowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working and Mental Hygiene. life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) SUPERVISOR DLLR Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 ALMA D. SUTTON EDWARD T. ALLEN injury or other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau once. EDWINA L. HOWARD (SISTER) 2820 ARLENE CIRCLE GWYNN OAK, MARYLAND 21207 Baltimore, 20a. Method of Disposition 1 Burial 2 Crema 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) ion 3 Removal from State 4 Donation 5 Donation 5 Donat (Specify) ENTOMBMENT BALTIMORE, MARYLAND ARBUTUS MEMORIAL PARK 3-21-2012 HIBNER. Name and Address of Facility PHILLIPS FUNERAL HOME, P.A. 21. Signature of Fund JONATHAN D. 1721-27 N. MONROE ST. BALTIMORE, MARYLAND 21217 Fuller the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest for heart failure. List only one cause on each line. 23a. Part 1 shock Approximate Interval Between Immediate Cause (Final Onset and Death Myocardia Physician/ Infarction disease or condition days Medical resulting in death) Due to as a consequence of): Examiner Chronic kidne Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Examine Cause (Disease or injury that initiated events resulting in death) Last Hyperlipidenia attending physician and for use as the burial-trai Due to (or as a consequence of) Physician/Medical End Heart -stage Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Dav 5 Other (specify) Year Pregnant at time of death signed by the a Part <mark>II. Other significant conditions</mark> contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Cerebrovascular accident 1 Yes 2 No 3 Probably 4 Nhknown cate has been sig Completed Vascular denertia 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Was an autopsy 26. Place of Death (Check only one) Be

Hospital or Attending Physician; The law requires that the death certificate be executed this certificate director, After 24 hours after deatl Funeral Director:

မှ

Certificate:

Medical

4 Homicide

25. Was case referred to medica

examiner? Hospital 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) . Manner of Death 1 X Natural 5 Pending Accident Investigation Suicide

6 Could not be determined

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28b. Time of

injury

28f. Location (Street and Number or Rural Route Number, City or Town, State)

March, 15, 2012

Other: 4 Nursing Home 5 Residence 6 B Other (Specify) HOSPICE

28d. Describe how injury occurred

29a. Certifier 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 3 🗆 only one 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie 29c. License numbe aule

28c. Injury at work? 1 ☐ Yes 2 ☐ No

RES DOD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MBBS

Sinai Hospital of Baltimore, 2401 W. Belvedu Ave, Bul Knon Mo MBBS PREYANKA

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day 2012 Month Physician/ 30 PM Conner, 16, Henry March Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (if not institution, give street and number) **Examiner** Westminster Carroll Carroll Hospital Center Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 5. Social Security Number **Funeral** Months Director 77 1 X M 2 - F Unknown Yrs. Oct 14, 1934 TI. Usual Residence of Decedent 28a-f show 10d. Inside City Limits 10a. State 10c. City, Town or Location 10b. County with the Maryland Director 1 Yes 2 No Mt Airy MD Carroll 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number ō ms 23a o must be Funeral U.S.A. 21771 4101 Old National Pike 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12 Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates. Black, White, etc 0 þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 X No Specify. Specify: "natural" Completed 3 - Widowed 4 - Divorced White h and Mental Hygiene.
27 is marked other than "natural" 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) Never Employed Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ၉ Stryker Henry W. Conner, Sr. Marv 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Department of Health ar Important: If item 27 is any injury or other trauonce. Lexington, SC Sister 124 Royal Lythan Drive Jane C. Holland 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 X Cremation 3 Removal from State 3/19/12 Hampstead, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Cremation Ser 22. Name and Address of Facility 11824 Reisterstown Road Stephen Sus ELINE FUNERAL HOME Reisterstown, MD 21136 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate nterval Between Onset and Death Immediate Cause (Final Dreumon Physician/ disease or condition Medical resulting in death) D e to (or as a consequence of) Examiner Sequentially list conditions Due to (or 45 a concequence or): Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) resulting in death) Last Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d, Date of delivery 3 T Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No 5 Other (specify) Pregnant at time of death 1 Yes 2 L 9 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy perform 26. Place of Death (Check only one) 25. Was case referred to medical Certificate: To Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 1 Inpatient 2 I ER/Outpatient 3 I DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at 1 Natural work? 1 ☐ Yes 2 ☐ No 5 Pending 2 Accident
3 Suicide
4 Homicide Investigation Could not be within 24 hours after deat To the Funeral Director: 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

200 Memorial Ave. Westminster, MD 21157 M.D.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State

Registrar

29a. Certifier

(Check

29b. Signature and title of certifier

Ajay Behari, 31. Date filed (Month, Day, Year)

MAR 2 0 2012

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29d, Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 2<u>012</u> Month Physician/ DEYESU LUCY 12:05P^M March Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore County MAYS CHAPEL Timonium LORIEN NURSING CENTER. 8. Date of Birth
(Month, Day Ye)
June 10, If Under 1 Year If Under 24 Hrs. Age (In vrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Min Hours Months 1916 Mary land 95 216-12-2505 Director Usual Residence of Decedent 28a-f show 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State death with the Maryland Examiner must be notified at Director 1 Yes 2 X No Maryland |Baltimore County Timonium 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ō permit. Page 1 and 2 should be filed within 72 hours after death with t Department of Health and Mental Hygiene. Bepartment of Health and Mental Hygiene any inportant; If item 27 is marked other than "natural", or items 23a any injury or other traumatic event the Maximal Factor of the result of of the Funeral 21093 USA 12230 Roundwood Road Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 14. Race - American Indian Black, White, etc. 1 🕅 Never Married 2 🗆 Married ģ 1 ☐ Yes 2 🔀 No If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Specify: White Completed 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 12 Printing Be 17, Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Carmela Fred Deyesu Romeo 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1402 Winsted Drive, Fallston, Maryland 21047 Carmen F. Deyesu (Nephew) 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State cemetery, crematory or other place) 3/21/2012 Moreland Mem Park Baltimore, Maryland Donation 5 Other (Specify) Medital Carles Sign Martin 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such we cardiac or shock, or heart failure. List only one cause on each line Interval Between Onset and Death Immediate Cause (Final Ph, sician/ disease or condition resulting in death) Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examine Due to (or as a consequence of) led by the attending physician and detached for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE 23d. Date of delivery 23b. Was decedent pregnant Live Birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month Day 5 Other (specify) Pregnant at time of death 1 ☐ Yes 2 ☐ 9 ☐ Unknown Unknown signed by t d be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 술 1 Yes 2 No 3 Probably 4 Vonknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Jas autopsy performed? Yes 2 A No Director: After this certificate 1 Yes 2 No Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital Other 2 **X** No ျ 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28b. Time of 28a. Date of injury (Month, Day, Year) 28d. Describe how injury occurred 28c. Injury at Certificate: Natural injury work? 1 ☐ Yes 2 ☐ No 5 Pendina Accident Investigation Suicide 6 Could not be 3 Suicide
4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, filled in by determined City or Town, State) 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

To the Hospital or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760 within 24 hours a

To the Funeral ination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one od title of certifier 29d. Date signed (Month, Day, Year) on who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) State MAR 2 0 2012 Registrar DHMH 17 Rev 7/2009 ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND TTEM#18perFH,G925,37272012,WS
State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death Reg. No. 2. Date of Death Month 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** nam /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Baltimore Jamari Hospital

Age (In yrs. last birthday) Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. Date of Birth (Month, Day, Sex 1 M 2 □ F 5. Social Security Number **Funeral** Months Days Hours Min 231-56-597 **Director** Usual Residence of Decedent 10d. Inside City Limits death with the Maryland 10a. State 10b. County 10c. City, Town or Location 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examinar must be notified at once. 1 Yes 2 □ No Funeral Director timore 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 2/2 eanwood 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian. 12. Was Decedent Ever in U.S Armed Forces? 11. Marital Status Black, White, etc. 1 ☐Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married 1 □Yes 2 No Baltimore, Maryland 21215-0036 Specify Specify: Black ð 3 Widowed 4 Divorced Be Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) Coljege (1-4or 5+) arvi ec 12+1 A 18. Mother's Name (First, Middle, Malden Surname) · Unkna 17. Father's Name (First, Middle, Last) Davis ပ Grace Davis 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Rd. Baltimure, nee MD Deanwood Date 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Parkwood timore, ameteri 22. Name and Address of Facility March Fltt-East 21. Signature of Funeral ervice Licensee 1101 E. North Avei Baltimore, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause or each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Tie to (or as a conse **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying cause. (Dicease or hijar) that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Hospital or Attending Physician: The law requires that the death certificate be executed burial-transi attending physician and for use as the burial-trar Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year Day in the past 12 months? 1 ☐ Yes 2 ☐ No 4 Pregnant at time of death 5 ☐ Other (specify) 9 Unknown After this certificate has been signed by funeral director, page 2 should be detach 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 3 Probably 4 Unknown 2 🔲 No 1 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐ Yes 2 ☑ No 2 🗹 No 1 ☐Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 1 ☐ Yes this Date of Injury (Month, Day, Year) 28b. Time of Injury 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 1 ☐ Yes 2 ☐ No death. 2 Accident 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Under the cause (s) and manner as stated.

Under the cause (s) and the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause (s) 29a. Certifier Medical (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number d title of certifier 29b. Signature a 30. Name and address of person who co mpleted ca se of death_(Item 23a) (Type, Print) 05 Registrar's Signature iled (Month, Day, 31. Date State MAR 2 0 2012 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) Date of Death 72012 Physician/ 150PM DO UGLAS Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** BALTIMORE 2722 W FAIRMONT AVE If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Hours 240-42-1955 80 **Director** 1 M 2-1 F 12/30/31 NCor 28a-f sho 10d. Inside City Limits 10b. County 10c. City, Town or Location Director BALTIMORE 1 🌠 Yes 2 □ No MD 10e. Street and Number 0 10f. Zip Code 10g. Citizen of What Country? must be Funeral 23a USA 2722 W FAIRMONT AVE 21223 within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian Black, White, etc. ō þ 1 Never Married 2 Married 1 ☐ Yes 2 ★ No If Yes, Give Year or Dates. Baltimore, Maryland 21215-0036 1 ☐ Yes 2x No Specify: Specify: BLACK "natural" 3 Xidowed 4 Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Il Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) the N/AHOUSEKEEPER PRIVATE 12 Be other traumatic event, Department of Health and Mental Hy Important: If item 27 is marked oth any injury or other transment. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 EPHRAM HOLMES WILLIE HUEY 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2722 W FAIRMONT AVE, BALTIMORE, MD 21223 GLORIA LEWIS/DAUGHTER 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 🔀 Burial 2 🗌 Cremation 3 🗋 Removal from State 3/26/12 BALTIMORE WOODLAWN CEMETERY 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility RONALD TAYLOR II FH of Funeral S WHITE PLAINS 10583 MIDDLEPORT LANE 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Medical **Examiner** Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Due to (or as a consequence of): resulting in death) Last Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ Mo
9 ☐ Unknown Month Day Year Pregnant at time of death Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by The law requires 2 No 3 Probably 4 Unknown 1 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an page 2 1 Yes 2 No Division of Vital To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific 25. Was case referred to predical 26. Place of Death (Check only one) Be 10 Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred 5 Pending
Investigation Natural 1 Yes 2 No Accident Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completely Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title

State Registrar ed (Month, Day, Year)

Box 68760

P.O.

Records,

of death (Item 23a

32. Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month March Physician/ 2012 3:50 p M Vincent David Dorsey Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Upper Chesapeake Medical Center Harford Air 7. Age (In yrs. last birthday) Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Social Security Number Funeral Min. Months Days Hours 216-58-3032 **Director** 1 ፟፟፟ M 2 □ F 61 July 12, Maryland Usual Residence of Decedent 28a-f show 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County Director notified 1 Yes 2 No Maryland Harford Edgewood 10f. Zip Code 10g. Citizen of What Country? 10e Street and Number 5 must be or Funeral 3901 Willoughby Beach Road 21040 items 2 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) "natural", or item ledical Examiner m 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 X Yes 2 No
If Yes, Give 1 Never Married 2 Married by Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Specificack/Caucasian 3 Widowed 4 Divorced Completed Year or Dates the Medical 16a, Decedent's Usual Occupation (Give kind of work done during most of working life, DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry and Mental Hygiene.
is marked other than Elementary/Secondary (0-12) College (1-4 or 5+) U.S. Government Military Be 18. Mother's Name (First, Middle, Malden Surname) 17. Father's Name (First, Middle, Last) 2 (unk) (unk) Helena (nmn) Dorsey (unk) other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health Important: If item 27 3901 Willoughby Beach Rd., Edgewood, MD 21040 Charles D. Dorsey / Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date 1 Burial 2 X Cremation 3 Removal from State injury or 4 ☐ Donation 5 ☐ Other (Specify) Rose Hill Svcs, LLC 3-19-12 Bel Air, Maryland 22. Name and Address of Facility McComas Funeral Home, P.A. 1317 Cokesbury Rd., Abingdon, 'n 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Immediate Cause (Final intacction Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): Cause (Disease or injury that initiated events -tran Due to (or as a consequence of): resulting in death) Last attending physician at for use as the burial Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 5 Other (specify) Pregnant at time of death been signed by the a should be detached DESEA, VINCENT MODULAGING Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ dystipidem HyperTension 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🗹 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy Yes 2 No Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital 2 🗆 No ည 1 Inpatient 2 ER/Outpatient 3 IDOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred Certificate: within 24 hours after death.

To the Funeral Director: After injury 1 Natural 5 Pending 2 Accident
3 Suicide Investigation Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town. State) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practificate: To the best of my movinion, death, commodel the time, date and place and date and place, and manner as stated. (Check 29b. Signature and title of 29c. License number 29d. Date signed (Month, Day, Year)

-/ 1 h

State 31. Date filed (Month, Day, Year)

Registrar MAR 2 0 2012

30. Name and addr

Fermin

32. Registrar's Signature

ess of person who completed cause of death (Item 23a) (Type, Print)

Barrueto

Jr. MD

00057223

upper Chasapanke Dr., Bel Air MD-21014

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. For State Registrar State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death Physician/ Edward John Daniels 18, 201^{Yea} 10:00 P M March Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Riverview Care Center Baltimore Essex Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) **Funeral** 1 🛛 M 2 🗆 F Days oct. 4, 1935 218 32 3880 76 Director Maryland Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits at Director the Medical Examiner must be notified Maryland Baltimore Essex 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? items 23a or USA with Funeral 1330 Maple Avenue 21221 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11 Marital Status Armed Forces? Black, White, etc. ō 1 Never Married 2 Married Completed by Yes Baltimore, Maryland 21215-0036 Specify: White 1 ☐ Yes 2 X No Specify: If Yes, Give "natural", 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry and Mental Hygiene. is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Owner/Operator Sanitation Engineer 12 other traumatic event, Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) John Nelson Daniels Florence Bock 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh
Department of Health an
Important: If item 27 is 1 Stella Cox (Daughter) 1330 Maple Avenue Baltimore, Maryland 21221 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 X Burial 2 Cremation 3 Removal from State Oak Lawn Cemetery 3/20/2012 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Licenses 22. Name and Address of Facility

Bruzdzinski Funeral Home_P.A. Maryland 21221 Burka 1407 Old Fastern Avenue Essex. 23a Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, nock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final I Ochanic Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) un-Known Examiner onom Esquentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of) and -tran that initiated events resulting in death) Last Due to (or as a consequence of): physician sthe burial Physician/Medical that the death certificate be Division of Vital Records, P.O. Box 68760 i by the attending parached for use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death Linknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No has certificate Yes 2 No 1 Yes within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, To the Hospital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital Other: 4 🗷 Nursing Home 5 🗌 Residence 6 🗎 Other (Specify) 1 🗌 Yes 2 🗶 No 1 Inpatient 2 ER/Outpatient 3 DOA မ 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Certificate: 1 X Natural 5 Pending 1 Yes 2 No ☐ Accident☐ Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Gertifying Nurse Practioner: To the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Gertifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier

DHMH 17 Rev 7/2009

Registrar

M-D.

MALICA

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

WASERM.

709. BASTERN BLVD. M.D. 21221

		Please	Type or Prin										ible.		
Dhusisia	,	State Registrar 1. Decedent's Name (First, Middle, Las	•		rtificate	of De	eath_		2. Date of Dea			Year	3. Time of Dea		
Physicia Medic Examin	al	Jack 4a. Facility Name (if not institution, give		1p	De	ean 4b. City, To			of Death	March March		c. County		11:03 A	4 M
Funeral		1 Sharondale Way, 5. Social Security Number 6. Security Number	7. Age	e (In yrs. la	st birthday)	If Under 1	SSEX Year Days	If Under Hours	Min.	8. Date of Birtl (Month, Day	; Year)		Cour	place (State or For	reign
Director	Funeral Director	213-60-3820 1. Usual Residence of Decedent 10a. State 10b. County	X M 2 □ F	58 10c. City	Yrs. , Town or La	ocation				Aug. 27	,19	53		/land Od. Inside City Li	mits
the Maryla or 28a-f		Maryland Baltim 10e. Street and Number	ore	E	Ssex	10f. Zip C	ode				10g. 0		What Cour		X No
permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		1 Sharondale Way,	12. Was Decedent E Armed Forces?		13.		1221 nt of His Cuban		gin? (Spe	ecify Yes or No- Rican, etc.)		14. Rac	e - Americ	an Indian,	
nours after atural", or ical Exami	To Be Completed by	1 X Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Ec	1 ☐ Yes 2 ☎☐ If Yes, Give Year or Dates.	No	16a, Dece	1 Yes 2	Occupat	tion			16b.	Specify.	WI	White ss/Industry	
within 72 t giene. er than "n , the Medi		(Specify only highest gra	nde co <i>mpleted)</i> College (1-4 or 5 4	+)	life. D	kind of work of NOT use re mputer	etired)			ing 	Computer Company				
ld be filed Mental Hy larked oth atic event		17. Father's Name (First, Middle, Last) Weston	Dea	an						shirley		В	eckei		
and 2 shou Health and em 27 is m iher traum		19a. Informant's Name/Relationship (T) Weston Dean F 20a. Method of Disposition	rpe, Print) ather	Laoh D	1211	ing Address (S O Tulla osition (Name	amor		ourt,		Tin	oniu	m, Ma	code) 21093 aryland own, State	
it. Page 1 aurunent of hintant: If ite		1 X Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specifical Signature) Luftera Service License	y)	Cre	ergetery.Icra	watery or other	er place	e of Facili	3-21	-2012	1arı	riott	svi1	le MD	
permi Depar Impor any ir		23a. Part 1. Enter the disease, or com	plications that caused	the deatl						ck Towson,		rylar	nd 2	Approximate	
Physician/ Medical Examiner		shock, or heart failure. List only o Immediate Cause (Final disease or condition resulting in death)	ne cause on each line	N(9	sder	- /	-	- 1		ascular		1 Sea	se	Interval Betwee Onset and Deat	
ath certificate be executed attending physician and for use as the burial-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as c. Due to (or as d.							-					
To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physicit completely filled in by the funeral director, page 2 should be detached for use as the but	by Physician/Medica	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	23c. If yes, outcome 1 Live Birth 4 Pregnant a 9 Unknown	2 Feta	al death 3	leath 3 Ectopic pregnancy							23d. Date of delivery Month Day Year		
uires that the signed by all doe deta		Part II. Other significant conditions of	ontributing to death b	out not res	ulting in the	underlying ca	use give	en in Par	t I.		23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown				
he law requate has bee bage 2 shot	Completed									24a. Was autop perfo 1 Yes	osy rmed?	ار		opsy findings avai ompletion of caus	
ician: T	Be	25. Was case referred to medical examine?	Hospital:				Othe			ck only one)					
ding Phys th. After this funeral dii	cate: To	1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending 2 Accident Investigatio	1 ∐ Inpat 28a. Date of inju (Month, Da	iry	28b. Time of injury	ent 3 DOA of 286	c. Injury work?	at LIN		ome 5 Residence 128d. Describe h				ý)	
To the Hospital or Attending Physician: The la within 24 hours after death. To the Funeral Director: After this certificate ha completely filled in by the funeral director, page	Certificate:	3 Suicide 6 Could not be 4 Homicide determined				treet, factory,	office			28f. Location (Street and Number or Rural Route Number, City or Town, State)					
he Hospit in 24 hour he Funera ipletely fille	Medical	(Check 2 Medical Exam	sician: To the best of iner: On the basis of e se Practitioner: To th	examination	n and/or inve	estigation, in m	y opinio	n, death d	occurred a	at the time, date a	ınd pla	ce, and du	ie to the ca	ause(s) and manne	r stated.
To t To t		29b. Signature and title of certifier	D Depu	ty		29c.	License	number	7			1	ed (Month,	Day, Year)	
		30. Name and address of person who Philip Militel	completed cause of c	leath (Item	1 23a) (Type,	Print) e Hill	C.	Lut	hero	ille M	D	210	993		
Sta Registr		31. Date 1 AR 2 0, 2012	32. Registr	ar Signa	park	1									

DHMH 17 Rev 06-2011

Division of Vital Records, P.O. Box 68760

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene
Amend Items 24a,26,27 per np, g925,03/20/2012dhb

Reg. No.
Reg. No. For State Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ March 7^{Day} 2012^{Year} 7:38 A M Dolle Gertrude Mary Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore Timonium Stella Maris If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) Social Security Number 6. Sex 8. Date of Birth 7. Age (In yrs. last birthday) **Funeral** Days Hours (Month, Day, 94 215-03-6579 Director 1 M 2 XF 1918 Maryland Feb. 14 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits notified at Director 1 Yes 2X No Maryland Baltimore Lutherville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ō must be Funeral 23a 21.093 U.S.A. 813 Branford Circle items death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Examiner Armed Forces Black, White, etc. o, þ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 filed within 72 hours after Yes 2 No If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: 'natural", Specify: White Completed 3 Widowed 4 Divorced Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) Department of Health and Mental Hygiene Important; If item 27 is marked other this any injury or other traumatic event, the once. Own Home Homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Mary C. Marx Charles F. Kehoe Page 1 and 2 should 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 813 Branford Circle, Lutherville, MD 21093 John H. Dolle / Husband 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State 3/15/2012 Timonium, Maryland DulaneyValleyMemGdns 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funer Lawre Frens 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. 1050 York Road Towson, MD 21204 23a. Part 1. Enter the disease, or combinations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician. THEROSE disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying attending physician and I for use as the burial-transit Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of 2012 Physician/Medical P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year been signed by the a should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ٥ Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an eral Director; After this certificate has filled in by the funeral director, page 2 autopsy performed? Yes 2 X N 2 🗌 No 1 Yes Division of Vital al or Attending Physician: s after death. I Director; After this certific 25. Was case referred to medical 26. Place of Death (Check only one) Be Hospital Other: 4 X Nursing Home 5 - Residence 6 - Other (Specify) DOLLE 1 Yes 2 No ပ္ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 XNatural 5 Pending work? 1 ☐ Yes 2 ☐ No Accident
Suicide Investigation GERTRUDE 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Hospital 24 hours a To the Hospital within 24 hours a To the Funeral I Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completely Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 2 une (29 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DULANEY VALLEY ROAD TIMONIUM, MD 21093 JUNECIA WHITE CRNP 2300 31. Date filed (Month, Day, Year) 32. Registrar's Signat

Registrar DHMH 17 Rev 06-2011

State

MAR 2 0 2012

8

8

246

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible.

AMEND ITEM#10f,19b,perFH,G925,3/27/2012,WS
State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 🗸 1. Decedent's Name (First, Middle, Last) 2 Date of Death Physician/ March 15 Day 2012 Charles Clayton Diggs 10:53 A M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Columbia Howard Gilchrist Hospice Birthplace (State or Foreign Country) Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 7. Age (In vrs. last birthday) **Funeral** Days Hours Min (Month, Day, Year) Director 220-10-0418 1 X M 2 🗆 F 93 August 16,1918 Maryland Usual Residence of Decedent show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural" any injury or other traumatic events. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 🗌 Yes 2 🙀 No Maryland Howard Columbia 10f. Zip Code **21045** 10e. Street and Number 10g. Citizen of What Country? Funeral 21044 U.S.A. 7030 Deepage Drive 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, 11. Marital Status Black, White, etc. Completed by 1 Never Married 2 Married Yes Yes, Give 2 No 1 ☐ Yes 2 X No Specify. Specify: 3 ₺ Widowed 4 □ Divorced White Army Year or Dates 15 Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Chemical Engineer Energy Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ျှ Charles Sherman Diggs Pearl Dietrich 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, Cit**29 1045** State, Zip Code)
7030 Deepage Drive Columbia, Maryland 21044 Elaine M. Diggs (Daughter) 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State Dulaney Valley Memorial Gardens 1 K Burial 2 Cremation 3 Removal from State 3-20-2012 Timonium, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Signature of Fuseral Service Licens 22. Name and Address of Facility Witzke Funeral Homes, Inc. This 5555 Twin Knolls Road Columbia, Maryland 21045 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, fock, or heart failure. List only one cause on each line. Approximate Interval Between mmediate Cause (Final Onset and Death Ph, i ian Week my disease or condition Medical resulting in death) **Examiner** Sequentially list conditions Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to r as a conseque ce of Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death. and that initiated events Due to (or as a consequence of): resulting in death) Last been signed by the attending physician should be detached for use as the buria Be Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?

1 Yes 2 No Day Month Year Pregnant at time of death 1 Yes 2 L 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has h autopsy 2 10 Yes 2 DIN 1 Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital Other: 2 🗆 No ျ 1 Tes ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Nother (Specify) 1 Inpatient 2 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at work? 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director: After 1 Natural 5 Pending 1 Yes 2 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Medical 1 Vertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 3/16/12 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) State Registrar

12-01833 Le

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

6

Leah Dittmar		State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2012 185													2 0250			
Physician/		egistrar . Decedent's Name	e (First, Middl	e,Last)		***						2	Date of Dea		Year	1:	3. Time of Death	
Medical Examine	r	LE					DIT'	TMAR					March 4,	2012	c. County of D		1308 hrs	
	4	la. Facility Name (in			street and nu	mber)			b. City, To Baltimo	,	ocation or	Death		140		N/A		
Funeral	5	. Social Security N		6. Sex	:	7. Age (Ir	yrs. last bir	thday)	If Under		If Under		8. Date of B	irth(MM	/DD/YYYY) 9		place (State or	
Director		218-22-	9482	1	м 2 🔀 F		92	Yrs.	Months	Days	Hours	Min.	09/1	9/1			ARYLAND _	
k	_	Jsual Residence of 0a. State	Decedent 10b. County			100	c. City, Town	or Locati	on								10d. Inside City Limits	
naw any		MD		/A					MORE								1 X Yes 2 No	
the Maryland a nr 28a-f shnw tifted at once.	1	Oe. Street and Nur		/ A		L	<u>D</u> .	WILT	10f. Zip C	ode	-			10g. Cit	izen of What	Count	ry?	
the M		1712	E. 33	rd	STREE	${f T}$				21	218				U.S.	. A .		
or items 23a ar 28a-f sha must be notified at once. Funeral Director		1. Marital Status 1 X Never Marrie	ad 2 M		12. Was Dec Armed Fo	orces?			s Decedent es, specify				cify Yes or Nican, etc.)	٥	14. Race - A White, e		an Indian, Black,	
9 F 1 T		3 Widowed			1 Yes If Yes, Give Yea	2 X	No	1	Yes 2	No No	specify:			Specify: WHI			ITE	
ours after annual.	2 F	15. Decedent's Ed			or Dates:		ted) 16a.	Deceden	t's Usual O	ccupatio				16b.	Kind of Busin	ess/In	dustry	
0036 within 72 hour giene. her than "natu Medical Exar		Elementary/Seco	ondary (0-12)		College (1	-4 or 5+)		during most of working life. DO NOT use reti										
5-0036 led within 7 Hygiene. Inther than the Medica	-	8 17. Father's Name	(First, Middle	Last)	_		<u>.</u>		SECK	_		Name (F	irst, Middle,			I*IP:	RILAND	
215- 215- be filed ntal Hyg rked ntl ent, the	<i>!</i>	HENRY		·		DIT	TMAR				LEAH		MAGD <i>I</i>	LEI		3EC		
ould Mer																Zip Code) 21234		
and 2 she ealth and ealth and I insumat	-1-	20a. Method of Dis		- 00	OSIN		20b. Place						Date		Location - Ci			
altimore, mit. Pages la ppartment of He pportant: If ite	- 1	1 X Burial 2		_	Removal fr	om State		tory or oth 17.7 <u>2</u> آریا		/ETTE	DV.	3/1/	5/12	BZ	τ.πτΜΩ	R F.	, MARYLAND	
altin mit. P. partmet portan		4 Donation 5 21. Signatur			iee /	1	OHR	22 N	ame and A	ddress c	of Facility							
-	4	23a. Part I. Enter th	all	10	The	all									NERALIC),	MD 21224 Approximate Interval	
Physician Wedical	1	23a. Part I. Enter th failure. List on		on ead	ch line.		death, Do r	iot enter ti	te mode of	dying, si	uun as cai	diac of i	espiratory ar	11031, 311	lock, of fleat		Between Onset and Death	
Immediate Cause (Final disease or condition resulting in death) a. Chest Injuries Due to (or as a consequence of):																		
		Sequentially list co		b	Oue to (or as a											_		
nsit Examine		if any, leading to in cause. Enter Unde (Disease or injury t	erlying Cause	C.	,													
ed nsit	Ya	events resulting in			Due to (or as a	consequ	ence of):											
execul an and al - tra		UNPENDED		 ייי	AMENDED	19a	per i	nf. g	925 3	-23-	-12 v	t						
760, cate be physici he buri		F FEMALE: 3b. Was decedent	prognant in t	ho			of pregnancy		-		7	_		23	3d. Date of de	-	Vees	
Box 68760, a death certificate b the attending physical for use as the but we clean / Merician/Mericia		past 12 months		110	1 Live b		e of death		tal death her <i>(Speci</i> i	3 <u> </u>	Ectopic	pregnan	СУ		Month	Da	ay Year	
). Box 68760 the death certificate by the attending physiched for use as the busician/Me		1 Yes 2 🗸 I		known	9 Unkn								Too Bu	1		1 - 4 - 41	and the state of	
P.O. Boost that the death gened by the attent of detached for the boost		Part II. Other signi	ificant condi	tions	contributing to	o death bu	ut not resulti	ng in the ι	ınderlying (ause giv	ven in Part	: I.	1				ne cause of death?	
cords, P.C : law requires that : has been signed to e 2 should be deta	3												24a, Wa				opsy findings available	
Records, The law requires ficate has been sig. page 2 should be														opsy formed?	dea		ompletion of cause of	
Division of Vital Records, rate darkeding Physician: The law requirers after death. al Director: After this certificate has been sited in by the funeral director, page 2 should be artification: To Be Completed		25. Was case refer	red to medica	al la					26	6.Place o	of Death (0	Check or				7 100		
Vital I bysician: bysician: this certification.	5	examiner? 1 ✓ Yes	2 No	Н	lospital: 1	Inpatient	2 🗸 ER/0						Home 5			Other:		
ivision of Vir lor Attending Physia after death. Director: After this d in by the funeral dir		27. Manner of Dea 1 Natural		ding	28a. Date FOUND	of Injury Day,Year) 28b UN	. Time of I			rat Work? es 2 ✔ I	ls.	18d. Describe Subject fel		njury occurred			
Sion Attend or death. rector: by the i		2 Accident	Inve	estigatio	Mar 4, 2	2012	y - At home,	farm, stre	et, factory,						and Number	or Rur	al Route Number, City	
Division o ospital or Attending hours after death, neral Director: Aft y filled in by the fune Contification:		3 Suicide 4 Homicide		ild not be ermined		Resid	lence					7	or Town, 12 E. 33rd	State) Street,	, Baltimore,	MD		
0 - = >		29a. Certifier (Check only		hysici	an: To the be	st of my k	nowledge, d	eath occu	red at the t	time, dat	e and plac	e, and d	lue to the ca	use(s) a	and manner as	state	d. cause(s)	
To the Ho within 24 To the Ro completel		one) 2 🗸	1		and manner						number				. Date signed			
		7		-						O.C.N	1.E.			Ma	arch 5, 201	2		
	+	30. Name and add	ress of perso	n who d	completed cau	se of dea	th (Item 23a))										
9		Donna M. \	/incenti, N	ID .	Assistant I	Medical	Examine		W. Balt	more	Street, I	Baltim	ore, MD 2	1223				
Stat ✓ Registra		31 Date filed (Mor	oth, Day, Year,))[14]	32	egistrar's	Signature	bar	المستك									
DHMH 17 Rev 1/200		PI P	U & TH	4U 1 4	- 100		0	RIGINA				-						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 3 Physician/ Year EMESSEN 2:02 AM. Medical 4a. Facility Name (if pt institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Ravan och N/A nore Social Security Number 6. Sex 1 X M 2 □ F If Under 24 Hrs 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) 8. Date of Birth **Funeral** Months 2-287 Hours 213-20-5350 86 Yrs Director Usual Residence of Decedent th and Mental Hyglene. 27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits filed within 72 hours after death with the Maryland Funeral Director Baltimore 1 XYes 2 ☐ No MD N/A 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2233 Homewood Ave. 21218 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married þ Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: Black 3 Divorced 4 Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Shipyard Shipyard Inspector 8th N/A Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Ballard Emerson Bertha Farmer of Health and Nitem 27 is ma 19a. Informant's Name/Relationship (Type, Print) Daughter Cynthia Emerson-Collins 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5909 Plainfield Ave. Baltimore, MD 21206 other 1 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date permit. Page 1 a
Department of P
Important: If ite
any injury or ot 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Cedar Hill Cemt. 3/23/2012 Baltimore, 21. Signature of Fune al Service Licensee 22. Name and Address of Facility March F/H-East 1101 E. 0-2montable North Ave. Baltimore, MD 21202 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician meso MKACZUM Medical Due to (or as a consequence of) Examiner Sequentially list conditions, Physician/Medical Examiner Due to for as a consequence of if any leading to immedicause. Enter Underlying ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 - Fetal death 3 ☐ Ectopic pregnancy
5 ☐ Other (specify) ____ in the past 12 months? Month Day Year Pregnant at time of death Yes 2 No Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🗹 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe certificate 1 ☐ Yes 2 ☐ No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) examiner? Other: 4 \(\text{Nursing Home} \) 5 \(\text{Residence} \) 6 \(\text{Other (Specify)} \) 2 No 1 🗹 Inpatient 2 🗀 ER/Outpatient 3 🗆 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred work? 1 ☐ Yes 2 ☐ No 1 🗹 Natural 5 Pending Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certified and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar 3900

31. Date filed (Month, Day, Year)

och

32. Registrar's Signature

oulevard, Baltimore, Maryland

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Entwistle Month Year DM Ohn 012 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Baltimore Parkville Oak Crest Care Center If Under 1 Year | If Under 24 Hrs. Date of Birth (Month, Day, 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) New Jersey Min 1**X** M 2□ F 155-14-4960 89 23, 1922 June Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 1 ☐ Yes 2X No Baltimore Parkville 10f. Zip Code 10g, Citizen of What Country? 10e. Street and Number 21234 8800 Walther Blvd. #1609 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 12. Was Decedent Ever in U.S Armed Forces? 11. Marital Status Black, White, etc. 1XXes 2 □ No
If Yes, Give
Year or Dates: 43 -52 1 Never Married 2 Married 1 ☐Yes 2 💢 No White Specify: 3 X Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) Western Electric Supervisor 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Jennie E. Copper William J. Entwistle 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Abingdon, MD 21009 Robert J. Entwistle/Son 321 Regal Drive 20b. Place of Disposition (Name of cemetery, crematory or other place)
Dulaney Valley
Memorial Gardens 20c. Location - City or Town, State March 19. 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 2012 4 ☐ Donation 5 ☐ Other (Specify) Timonium, MD 21. Signature of Funeral Service Lie 22. Name and Address of Facility Lemmon Funeral Home of Dulaney Valley, Inc. Michael J. Flagle 10 W. Padopia Road Timonium, MD 21093 23a. Frt1. Ent. List disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, she is a heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final UMSNIA disease or condition resulting in death) Sequentially list conditions. cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): IF FEMALE 23d. Date of delivery Month Day Year use contribute to the cause of death? 3 Probably 4. Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 □Yes 2 □ No 6 ☐ Other (Specify) ry occurred

Examiner Examiner law requires that the death certificate be executed Physician/Medical Medical Certification: To Be Completed by Vital al or Attending P s after death. Il Director: After t Hospital within 24 hours a

2

P.0.

of

Physician

/Medical

Examiner

Director

Funeral

ģ

Completed

Be

ပ္

MD

Funeral

Director

72 hours after death with the Maryland

permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Expriner is ust be medical as

Physician

* /Medical

23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregns 1 ☐ Live birth 2 ☐ Feta 4 ☐ Pregnant at time of o	I death 3 Ectopic											
Part II. Other significant conditions	contributing to death but not res	ulting in the underlying	cause given in Part I.	23e. Did tobacco u 1 ☐ Yes 2									
- dysp	hagia			24a. Was an autopsy performed?									
25. Was case referred to medical		26. Place of Death (Check only one)											
examiner? 1 Yes 2 No	Hospital: 1 ☐ Inpatient 2 ☐	ER/Outpatient 3 1	OCA Other: 4 Nursing	Home 5 ☐ Residence									
27. Mann of Death 1 Natural 5 Pending 2 Accident investigat		(Month, Day, Year) Injury Work?											
3 ☐ Suicide 6 ☐ Could not determine	28e. Place of Injury - At no	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)											

(Check only 29b. Signature and title of certifier

nd Number or Rural Route Number, 輝 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) wather Bluf 31. Date filed (Month, Day, Year)

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Certificate of Death Registrar L Decedent's Name (First Middle | ast) 2. Date of Death Physician/ Warch 3:55 pm Olive A. Evans 2012 Medical Facility Name (if not institution, give, street and number) Location of Death **Examiner** 4c. County of Deatl N/A More a 8. Date of Birth (Month, Day, Year) **Sep 9, 1925** . Age (In yrs. last birthday) 24 Hrs Birthplace (State or Foreign Country)
 Penn. **Funeral** Penn. 1 🗆 M 2 🗀 F 86 Director 210-20-8948 Usual Residence of Deced or 28a-f show e notified at State 10b. County 10c. City, Town or Location 10d. Inside City Limits death with the Maryland Director X 1 Yes 2 No **Baltimore Baltimore City** MD ŏ 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? ms 23a oi Funeral 21216 U.S.A. 3110 Normount Avenue items 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Examiner Black, White, etc. ŏ 1 Yes 2X No If Yes, Give þ 1 Never Married 2 Married Saltimore, Maryland 21215-0036 filed within 72 hours after Black 1 Yes 2 No Specify "natural", Specify Completed 3 ¥ Widowed 4 ☐ Divorced Year or Dates the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) and Mental Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) **Health Care Medical Analyst** 12 other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Elizabeth Stoney should be Thomas H. Dillary 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) . Page 1 and 2 sh tment of Health a tant: If item 27 is 3110 Normount Avenue Baltimore, MD 21216 Karen Evans 20a, Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1XI Burial 2 🗌 Cremation 3 🗌 Removal from State Department of Important: If any injury or Baltimore, Md Mar 27, 2012 **Baltimore National Cemetery** 4 ☐ Donation 5 ☐ Other (Specify) Signature of Juneral Service 22. Name and Address of Facility
Estep Brothers Funeral Service, P. A.
1300 Eutaw Place Baltimore, Md 21217 Enter the disease, or complications that ca sed the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on ea Immediate Cause (Final Physician/ disease or condition resulting in death) LHEIMERS wxwon Medical Due to or as a consequence of Examiner Sequentially list conditions, if dry, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events ner Due to for as a consequence cir. Exami Hospital or Attending Physician: The law requires that the death certificate be executed g physician and as the burial-tran resulting in death) Last Due to (or as a consequence of): the attending physician Physician/Medical \mathcal{L} VMハシ) // // // Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 3 Ectopic pregnancy To the Funeral Director: After this certificate has been signed by the atte completely filled in by the funeral director, page 2 should be detached for Dav Year 5 Other (specify) Pregnant at time of death 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has autopsy performed? 1 Yes 2 No Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) 2 No Hospital 1 Yes မ ER/Outpatient 3 DOA 1 Inpatient 2 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work?
1 Yes Certificate: 28d. Describe how injury occurred 1 Natural 5 Pending injury 2 No Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 \square Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 70718 MARCH 16 2017 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BACTIMORF 900 MD 21279 DARK SOUTH CATTEN 31. Date filed (Month, Day, 32. Registrar's Signature State MAR 2 0 2012 Registrar

H DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State		State of N	Maryland		ırtment o <i>tificate o</i>				0	0.1	2 00000		
	Dhyoicia	n/	Registrar 1. Decedent's Nam	,	ast)					•	2. Date of Dea	ath	Year	3. Time of Death 5:00p M		
i de na	Physicia Medic	al			one (EATO	N	4b. City, Town		on of Dooth	Month 3	12	12			
- A	Examin	er	4a. Facility Name (II	-	st Barre Stree			4b. City, lowi		Itimore		4c. County of Death N/A				
ı	Funeral Director		5. Social Security N 215-80- 4	Age (In yrs. last	birthday) Yrs.	If Under 1 Ye Months Da		der 24 Hrs. S Min.	8. Date of Birl (Month, Da Aug	h /5, 1965	9. Birthplace (State or Fore Country) MD					
	and show at	or	Usual Residence of 10a. State	Decedent 10b. County		10c. City, 1	Town or Loc	ation						10d. Inside City Limits		
	Maryla 28a-f s otified	irect	MĎ		more City					ltimore				1 ☐ Yes 2 ☐ No		
	with the 23a or ust be n	Funeral Director	10e. Street and Nur 815 West	^{mber} Barre Stree	t			10f. Zip Coo		1230		10g. Citizen o	Citizen of What Country? U.S.A.			
21215-0036	ge 1 and 2 should be filed within 72 hours after death with the Maryland tt of Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at	by	11. Marital Status 1 X Never Marr 3 Widowed	ried 2	12. Was Deceden Armed Forces 1 Yes 2 If Yes, Give Year or Dates	No No	lf If	Vas Decedent of Yes, specify C	uban, Mexi	14. Race - American Indian, Black, White, etc. Specify: Black						
215-(יסן 72 ה an "nat Medica	Completed	(Spe	15. Decedent's ecify only highest g			(Give F	ent's Usual Oc ind of work do NOT use retin	ne during m ed)		ing	16b. Kind of	16b. Kind of Business Industry			
	d withir lygiene ther than nt, the	Be Co	1	12		(1 5+)			Cashie					onald's		
land	should be filed within n and Mental Hygiene. ris marked other tha raumatic event, the I	일	17. Father's Name (First, Middle, Last	Randolph	Eaton			18. Me	other's Nam	e (First, Middle,	Brenda E				
Maryland	d 2 should alth and N 1 27 is ma		19a. Informant's Na		Type, Print)			g Address (Str. 4 West Cr	eet and Nur	mber or Rura Street B	altimore, l	r, City or Town	, State, Zi	te, Zip Code)		
Baltimore,	Pa ant iry				Removal from Sta		netery, cren	sition (Name of natory or other ern Cernete	olace)	i	Date 19, 2012					
Balt	permit. Page Department Important: i any injury o		21. Sign dur Tru	neral Service Lice	nsee S-	tes	22	Name and Ac Estej 1300	dress of Fa Brothe Eutaw P	rs Funer Place Balt	al Service, imore, Md	P. A. 21217				
23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.														Approximate Interval Between Onset and Death		
6	Physician/ Medical		Immediate Cause disease or condition resulting in death)		a. Pulmi Due to (or a	nary as a constant	Emk	polism						Onoc and Down		
	Examiner	-K	Sequentially list co	onditions,	b. Sickl	le Cel	1 D	sease						month		
	ted d insit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or ilinjury													
	cate be executed physician and the burial-transit	al Ex	that initiated event resulting in death)		Due to (or a	as a consequer	nce of):									
200	icate be physics the b	ledical			₫ d											
Box 687	to the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director. After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/M	IF FEMALE: 23b. Was decedent in the past 12 1 ☐ Yes 2 ☐ 9 ☐ Unknown	23c. If yes, outcon 1 ☐ Live Birt 4 ☐ Pregnan 9 ☐ Unknow	_			Date of de Month	of delivery th Day Year							
s, P.O.	v requires that the de been signed by the should be detached		Part II. Other signi	ficant conditions	contributing to death								cco use contribute to the cause of death?			
ord	w requi	Completed by	Ol								24a. Was			utopsy findings available completion of cause of		
Rec	Physician: The law rithis certificate has are director, page 2 s										1 🗆 Yes	2 No	death?	s 2 No		
Vital	s certifi	To Be	25. Was case referr examiner? 1 Yes 2	/	Hospital:	atient 2 🗆 EF	B/Outpatier		Othor:	Death (Chec	k only one) ome 5 Resi	dence 6 🗆 O	ther (Spe	cify)		
Division of Vital Records,	nding Phy uth. ; After this e funeral d		27. Manner of Deat 1 Natural 2 Accident	th 5 Pending Investigati	28a. Date of in (Month, I		8b. Time of injury	28c. I	njury at vork?		28d. Describe h					
ivisio	Il or Atte after dez Director	Certificate;	3 ☐ Suicide 4 ☐ Homicide	6 Could not determine	28e. Place of I	Injury - At hom etc. (Specify)	e, farm, stre	eet, factory, off	ce		28f. Location (S City or Tov		nber or Ru	ıral Route Number,		
_	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completed filled in by the fu	Medical	(Check 2	Medical Exa	ysician: To the best miner: On the basis o	of examination a	ind/or invest	igation, in my o	pinion, deat	h occurred a	t the time, date a	and place, and	due to the	cause(s) and manner stated.		
	only one) 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place of the pl										, 200 10 11	29d. Date sign				
			30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Peoples Community Health Center													
\			30. Name and addr	hinghm	Blvd	Baltr	wore.	> MD	2	123	O HOO!	De	. Jog	elyo threes		
	Sta Registr	te ar	31. Date filed (Mont	2 0 2012	32. Regis	strar's Signatu	ale									

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend items 17,18 per fh g925 3-23-12 vt. State of Maryland / Department of Health and Mental Hygiene AMEND ITEM# IperPHYS# sperFH, G925, 3/27/2012, WS. Certificate of Death Reg. No. 2 State Registrar Reg. No. 1. Decedent's Name (First, Middle, Last)
Fredrick A. Egan
Egan 2. Date of Death Physician/ 2012 March 6:30 A M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 8300 Burdette Rd. Apt. B671 Bethesda Montgomery If Under 1 Year If Under 24 Hrs. 8. Date of Birth

(Month Day Year)

9-19-1921

Sept Social Security Number Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Min. Days Hours 221-30-4287 Director 1 **X** M 2 □ F 90 Brazi1 Usual Residence of Decedent items 23a or 28a-f show her must be notified at 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. item 27 is marked other than "natural", or items 23a or 28a-f shov 10a. State 10b. County 10c. City, Town or Location 10d, Inside City Limits Director MD Montgomery Bethesda 1 XYes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 8300 Burdette Rd. #B671 20817 United States Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 1. Marital Status 14. Race - American Indian, "natural", or iter edical Examiner or Armed Force Black, White, etc. 1 ☐ Yes 2 X No If Yes, Give Š 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 XYes 2 No Specify: Brazilian White 3 Divorced Specify: Completed Year or Dates Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) er than the Elementary/Secondary (0-12) College (1-4 or 5+) Executive Business (Dupont) 12 traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Charles Joseph Egan Dorothy Higgs 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Philip Manville / Son-in-Law 5404 Spangler Ave., Bethesda, MD 20816 If item 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Department of H Important: If ite any injury or ot once. 1 Burial 2 X Cremation 3 Removal from State Chesapeake Crematory 03/20/2012 Beltsville, MD 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Lice m00382 Rapp Funeral and Cremation Services 933 Gist Ave., Silver Spring, MD Dohn 20910 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between DAY'S Death Immediate Cause (Final CEREBROVASCULAR ACCIDENT Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner MYOCARDIAL INFARCTION 1 WEEK Sequentially list conditions, ne if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to for as a consequence of Exami To the Hospital or Attending Physician: The law requires that the death certificate be executed the burial-transit and Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 ass IF FEMALE: use 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? should be detached for Month Pregnant at time of death 2 No 9 Unknown 9 Unknown signed by Part II, Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3X Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy performed? Yes 2 No 2 🗌 No 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital Other: 1 ☐ Yes 2 XNo မ 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 X Residence 6 Other (Specify) funeral 27. Manner of Death 1 X Natural 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending injury work?
1 ☐ Yes 2 ☐ No the Accident Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 29a. Certifier within 24 hou To the Fune completely fi Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated only one) Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and ti of certifier 29d. Date signed (Month, Day, Year) D19294 MARCH 19, 2012 MA 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MELNICK M.D 911 RUSSELL AVE., 20875 JOHN/ R. GAITHERSBURG, MD 32. Registrar's Synature 31. Date filed (Mon) Day, Year) State Registrar

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Rea. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Miam Foler 4:40 AM Medical 4a. Facility Name (if not institution, give street and number 4c. County of Death Examiner 4b. City, Town, or Location of Death Westown Baitmer Baltiner ma If Under 1 Year If Under 24 Hrs. Social Security Number 7. Age (In yrs. last birthday, 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 XM 2 □ F Hours Min Sept 2, 87 033-14-0959 Massachusetts **Director** Usual Residence of Decedent 10b. County 10a. State 10c. City, Town or Location at 10d. Inside City Limits Director notified 28a-f 1 Yes 2X No Maryland Baltimore Baltimore 10e. Street and Number 10f. Zip Code 5 10g. Citizen of What Country? ms 23a or must be r permit. Page 1 and 2 should be filed within 72 hours after death with Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a any injury or other traumatic event, the Medical Examiner must b. Completed by Funeral 719 Maiden Choice Lane, HR 232 21228 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 X Yes 2 No
If Yes, Give Black, White, etc. 1943 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify. White 1946 3X Widowed 4 ☐ Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) 12 College (1-4 or 5+) Bus Driver Mass Transit Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည William J. Foley Helena May Dunham 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7364 Gardenview Drive Elkridge, Maryland 21075 JoAnne Blum, Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) New Cathedral Cemetery 03/19/12 Baltimore, Maryland 22. Name and Address of Facility MacNabb Funeral Home, P.A. 301 Frederick Road Catonsville, 21. Signature of Funeral Service Lice Thomas Gregor Thomas Maryland 21228 23a. Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ ymphoma disease or condition resulting in death) Medical Due to or as consequence of) **Examiner** Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease of injury that initiated events attending physician and for use as the burial-tran resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy ertificate has been signed by the attendictor, page 2 should be detached for use 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? Day Pregnant at time of death 5 Other (specify) Month Year 1 ☐ Yes 2 ¥ 9 ☐ Unknown 9 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by eval 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 2 🗆 No 1 Tes 25. Was case referred to medical exami*n*er?
1 ☐ Yes 2 No Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No Hospital To the Hospital or Attending Physic within 24 hours after death.

To the Funeral Director: After this completed filled in by the funeral dir. မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred 1 Natural 5 Pending 2 Accident Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated

Hagistrur

(Check

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Ann Butterworth, CRNP 709 Mardencho, a Lone Balto Wid 21228

In M. Betterwish CRAS

31. Date filed (Month, Day, Year)
MAR 2 0 2012 32. Registrar's Signature

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Contrigue Nurse Practice of the basis of my income and of the time date and people and out to the cause(s) and manner stated. 29c. License number

RO82382

29d. Date signed (Month, Day, Year)

3-15-12

12-02071 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Andrew Maurice Fisher State of Maryland / Department of Health and Mental Hygiene 2012 08603 1- For State Certificate of Death Registrar

1. Decedent's Name (First, Middle,Last) 2. Date of Death Physician/ 3. Time of Death Month Day March 12, 2012 **Medical Examiner** 0350 hrs Indrew Maurice 4a. Facility Name (if not institution, give street and number 4b. City, Town, or Location of Death c. County of Death Northwest Hospital Randallstown **Baltimore County** 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or 6. Sex **Funeral** Months Days Hours Director 1 M 2 F Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No or 28a-f shov must be notified at once. Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene.
sant: If item 27 is marked other than "natural", or items 23a or 28a-f sho Director 10g. Citizen of What Country? 10e Street and Number 10f, Zip Code Funeral 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, 2 Married Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. 1 Never Married 1 Yes 2 No 4 Divorced If Yes, Give Year or Dates: Specify: Black 1 Yes 2 No specify: traumatic event, the Medical Examiner á 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16h Kind of Business/Industr Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 17 Father's Name (First Middle Last) 18 Mother's Name (First Middle Maiden Surname æ Fisher 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Luca MD 21208 1 20b. Place of Disposition (Name of cemetery, 20c. Location crematory or other place) Burial 2 Cremation Donation 5 Other Specify 22. Name and Address of Facility Sanature of Funeral Service Ligenses 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear Approximate Interval **Physician** failure. List only one cause on each line. Between Onset and Medical Death a. Sharp Force Injuries Immediate Cause (Final disease xaminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of) Examine cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and transit Physician/Medical UNPENDED AMENDED signed by the attending physician be detached for use as the burial -Division of Vital Records, P.O. Box 68760, IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the 1 Live birth 3 Ectopic pregnancy Month Day Fetal death Year past 12 months? Pregnant at time of death 5 Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>۾</u> 1 Yes 2 No 3 Probably 4 Unknown funeral director, page 2 should be Completed After this certificate has been 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of performed? death? Yes 2 No 1 🗸 Yes 2 No To the Hospital or Attending Physician: within 24 hours after death.

To the Fuoeral Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical 26.Place of Death (Check only one) B examiner? Hospital: 1 ✔ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other Nursing Home 5 Residence 6 Other 1 🗸 Yes 2 No 28a. Date of Injury (Month, Day Year) Mar 11, 2012 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: Subject assaulted Natural 0000 hrs 1 Yes 2 ✔ No Pending Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City 6 Could not be Suicide or Town, State) 3802 Pikeswood Drive, Randallstown, MD determined (Specify) A residence 4 V Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) March 12, 2012 O.C.M.E. 30. Name and address of person who completed cause of death (Item 23a) Carol Allan, MD Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223 Day State

DHMH 17 Rev 1/2001 OCME 2006

Registrar

FELDER, REV WILLIAM

			Ple	ease Type o							-		_	ible.				
			For State	State	of Ma	aryland		artment of I tificate of I		and M	lental Hy	_	20	12	0.8	601		
	_		Registrar 1. Decedent's Name (First, Mid	dle, Last)				uncate or i	Jeaur		2. Date of De	Reg. N	o. <u>/</u> U	16.	3. Time o	f Death		
	Physicia Medic		William		В			Felde	r		MARC	H	18 a	Year 2012		00AM		
1	Examin		4a. Facility Name (if not instituti		7:410	DE	4b. City, Town, o		4c. County of Death									
-	Funeral		SINAI HOSF 5. Social Security Number	6. Sex		e (In yrs. last		BAL7 If Under 1 Year	-		8. Date of Bi	rth		9. Birthp	lace (State	or Foreign		
	Director		248-32-4429	1 X M 2 □ F		87	Yrs.	Months Days	24 Country) SC									
	ind show at	or	Usual Residence of Decedent 10a. State 10b. Cour			10c. City, T	Town or Lo	cation			02 0	2		1	0d. Inside C	ity Limits		
	Maryla 28a-f s otified	rect	MD N	ΙA		Bal	ltim	ore							1 X Ye	s 2 🗆 No		
	e filed within 72 hours after death with the Maryland tal Hygiene. And Hygiene. And other than "natural", or items 23a or 28a-f show other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	Funeral Director	10e. Street and Number 3238 Sequoia	Δυρ				hat Coun	try?									
	ath wi	uner	11. Marital Status	12. Was Dec	edent E	ver in U.S.	13. \	e - Americ	an Indian.									
õ	fter de , or its amine	by	1 Never Married 2 N	Armed F	orces?			Vas Decedent of H f Yes, specify Cuba □ Yes 2 → No			Rican, etc.)		Black	k, White, 6	nite, etc.			
Maryland 21215-0036	ours a atural' al Exa	Completed	3 Widowed 4 Divord	ed Year or I	ates.			Blac										
<u>.</u>	n 72 h an "na Medio	mple		hest grade completed			(Give I	lent's Usual Occup kind of work done O NOT use retired)	during mos	st of worki	ng	160.	Kind of Bu	isiness/ind	dustry			
77	l withii ygiene her th t, the		6th grade	na	1-4-01-3		M	<u>inister</u>					Chur					
and		To Be	17. Father's Name (First, Middle Nero Felder	e, Last)							e (First, Middle illfor		n Surname,)				
32	1 and 2 should be file of Health and Mental I item 27 is marked of other traumatic eve		19a. Informant's Name/Relatio	nship (Type, Print)	-		19b. Mailir		er, City or Town, State, Zip Code)									
	2 ± 2 ±		Charlie Walt	ers-Son		- 1		atimer										
ore	0		20a. Method of Disposition 1 XBurial 2 Cremati	on 3 🗆 Removal from	n State	20b. Plac	ce of Dispo netery, cren	sition (Name of natory or other pla	се)		Date	20c.	Location -	City or To	wn, State			
Baltimore,	permit. Page Department Important: I any injury or once.		4 Donation 5 Othe 21. Signature of Furral Service			Di		Ridge		3/23	3/12	Pi	kesv	rille	e, Mo			
Ra	permit. Departr Importa any inju		21. Signature of Futural Service	Mull	2		M.	Name and Address arch F/ 300 Wab	H We ash	št Ave,	Balt	imo	re,	Md :	21215	<u>;</u>		
			23a. Part 1. Enter the disease, shock, or heart failure. Li	or complications that	caused	the death. E									Approxima Interval Be			
Immediate Cause (Final disease or condition														1	Onset and	Death K		
ار	Medical Examiner		resulting in death)	Due to	. `	REAT	,	CANCE	2						lye			
	2010	ner	Sequentially list conditions, it any, leading to immediate cause. Enter Underlying	b. Duck		100	consequence of:											
O	executed an and irial-transit	Examiner	Cause (Disease or injury that initiated events	c										\perp				
_	e exectorian a		resulting in death) Last	Due to	or as	a consequen	ice ot):											
9	certificate be nding physic use as the bu	ledic		d														
Box 68/60	ath certificate be exvattending physician for use as the buria	an/M	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, or			f pregnancy : ☐ Fetal death 3 ☐ Ectopic pregnancy									te of delivery		
9 P	death the atte	Physician/Medica	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4 🗌 Pre 9 🗍 Un		t time of dea	ath 5	Other (specify)	Moi	Month Day Year								
J.	sician: The law requires that the dec certificate has been signed by the a rector, page 2 should be detached	y Ph	Part II. Other significant cond				_				23e. Did	tobaccc	use contr	ibute to th	ne cause of	death?		
18, 1	quires t en sign ould be	q pa	DIABETES	Chronic o	str	uctiv	e lu	ng dise	ase	-	1 □	Yes	2 🗌 No	3 🗆 Prol	oably 4 🗷	Unknown		
COC	aw rec las ber 2 sho	Completed by	HYPERTENSIO.	N, Coinge	STIV	E HE	ART	FAIWR	E,		24a. Was	DDSV	P	prior to co	ere autopsy findings available ior to completion of cause of			
Ř	: The licate h				156	, ga	01701				1 Yes	formed?	No 1	death?	2 🗆 No			
/Ital	ysician: s certific director,	To Be	25. Was case referred to medic examiner? 1 \sum Yes 2 \textcal{X} No	Hospital:	Innoti	ont 2 🗆 🗆	2/Outpotion	26. P	lace of Dea		me 5 Res	idonoo	e 🖾 Otho	or (Specify	HOSP	ice		
0	ig Phys ter this neral di		27. Manner of Death	28a. Dat		ry 28	Bb. Time of injury		ry at		28d. Describe				,			
0	Attending Physician: or death. ector: After this certific by the funeral director,	Certificate:		stigation				M 1	Yes 2	No					0			
>	1			rminod 28e. Plac		iry - At home c. (Specify)	e, farm, str	eet, factory, office			28f. Location City or To			er or Hurai	Houte Nurr	iber,		
	To the Hospital or within 24 hours after To the Funeral Dir completely filled in	Medical		ing Physician: To the												anner state		
Check 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, only one) 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and d											the cau	se(s) and m	nanner as s	stated.	- State			
	5 × 6 × 9		29b. Signature and title of certification.	ndra Jungt		10								Pd. Date signed (Month, Day, Year) MARCH , 18 , 2012				
	5					eath (Item 23	3a) (Type, F	Print)	0.4									
	٧		30. Name and address of person SHAILENDR 31. Date filed (Month, Day, Yea.	A SINGH	, 3	INAL	HOSF	DITAL OF	SAL1	MOK	E, 21	101	w. Be	iveae	TE MVC	- 4141		
	Sta		31. Date filed (Month, Day, Yea.	2012	Registra	ar's Signature	gar	44										

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day Month Year **Physician** BETTY 14:17M MARCH 2012 FILES J /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Johns Hopkins Bayview Medical Center **Baltimore** If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1 M 2 XF 78 216-34-6516 INUST **Director** Usual Residence of Decedent 10d. Inside City Limits Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10c. City, Town or Location ral", or items 23a or 28a-f show Examiner must be notified at 10a. State 10b. County 1 Yes 2 □ No Funeral Director tireore 10e. Street and Number 10g. Citizen of What Country? 10f. Zip-Code W-5/A 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ♠ No If Yes, Give 14. Race - American Indian 11. Marital Status 12. Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No 'natural", or ģ 3 Widowed 4 Divorced Year or Dates Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education the Medical (Specify only highest grade completed) than Elementary/Secondary (0-12) College (1-4 or 5+) OWN HOME 817 other 18. Mother's Name (First, Middle, Maiden Surname, or other traumatic event, 17. Father's Name (First, Middle, Last) Be is marked of ACEY ၉ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Department of Health ar Important: If item 27 is any injury or other trau once. 136 20b. Place of Disposition (Name of cemetery, crematory or other) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 Burial 2 Cremation 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Edneral Service Licensee 05c 120 Approximate Interval Between PAITO 23a. Part 1. Enter the disc shock, or heart failur fiplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, one cause on each line. Onset and Death Immediate Cause (Final **Physician** HYPOXIA disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner PULMONARY ED EMA Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner RESPIRATORT or Attending Physician; The law requires that the death certificate be executed DISTRESS the burial-tran resulting in death) Last Due to (or as a consequence of) attending physician Box 68760. Physician/Medical INFECTION URINARY IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live birth 2 Fetal death 3 Ectopic pregnancy Day in the past 12 months? Pregnant at time of death 5 Other (specify) Yes 2 No Division of Vital Records, P.O. Unknown 9 Unknown à 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I þ funeral director, page 2 should be No 3 Probably 4 Unknown 1 🗌 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 No 2 □ No 1 TYes 1 Tyes 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital: 1 Mopatient 2 No Other: 4 \square Nursing Home 5 \square Residence 2 ER/Outpatient 3 DOA 1 🗌 Yes 6 Other (Specify) Certification: To this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After t 1 Natural Pending investigation Injury 1 Yes 2 🗌 No death. 2 Accident filled in by the after death Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 🗌 Homicide Hospital 24 hours 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (check only one) Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 2 and manner stated. within 2 To the the 29c, License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie 2

State

11595

Registrar NAR

30. Name

31. Date filed (Month, Day

RES-000

2012

4940 Eastern Avenue, Baltimore, MD, 21224

PHY

address of person who completed cause of death (Item 23a) (Type, Print)

32. Regist

MD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 4:00 PM Anna Louise Florio Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner ManorCare Health Services Towson Baltimore If Under 1 Year | If Under 24 Hrs. Social Security Number . Age (In vrs. last birthday) 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** Days Hours Min (Month, Day, Year) Director 215-34-2994 1 🗆 M 2 🗷 F 75 01/21/1937 West Virginia 28a-f show 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits with the Maryland **Funeral Director** notified 1 X Yes 2 No MD Baltimore Towson 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code ö ms 23a or must be lll West Road 21204 U.S.A. items 1 and 2 should be filed within 72 hours after death of Health and Mental Hygiene. 12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. ö þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify. Specify: "natural" Completed 3 X Widowed 4 Divorced White Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) Give kind of work done during most of working life. DO NOT use retired) than Elementary/Secondary (0-12) College (1-4 or 5+) the 11 Food Service Waitress event, th Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Ith and Mental H
27 is marked of
traumatic ever မ Robert Graham Wyatt Alice Louise Haris 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Grand-27 Samantha Winterling daughter 2517 1/2 Sycamore Ave., Edgemere, MD 21219 item 2 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 듄 Department of Important: If it any injury or o once. ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State cemetery, crematory or other place) Anatomy Gifts Registry | 03/20/2012 | Hanover, Maryland 4 X Donation 5 ☐ Other (Specify) 21. Signature Funeral Service Licensee 22. Name and Address of Facility Anatomy Gifts Registry 7522 Connelley Dr., Ste. P, Hanover, MD 21076 or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, 23a. Part 1. Enter the disease shock, or heart failure. L Immediate Cause (Final Onset and Death Ph_sician/ gronar arter disease or condition resulting in death) Medical Due to (or as a consequent f) **Examiner** Sequentially fist conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of): Stag and the burial-tran or Attending Physician: The law requires that the death certificate be execu Due to (or as a consequence of) attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months?

1 Yes 2 No for Month Day Year Pregnant at time of death signed by the at be detached for 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 XYes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s has autopsy performe Yes 2 No 1 Yes funeral director. 25. Was case referred to medical To Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA after death.

Director: After this 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred X Natural 5 Pending 1 Yes 2 No Investigation 6 Could not be Accident 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Hospital the Funeral Medical 29a. Certifier 1 🕱 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 2 Medical Examiner: On the pasts of examination afficient investigation, intrity option, a data and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar

DHMH 17 Rev 06-2011

tallscrot

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

1012

32. Registrar's Signature

+ Sadi

31. Date filed (Month, Day, Year)

MAR 2 0 2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death March Physician/ Funk Edward J. 2012 5:15 Αм Medical 4a. Facility Name (if not institution, give street and number, 4b. City. Town, or Location of Death 4c. County of Death **Examiner** 1055 W. Joppa Rd. #319 Towson Baltimore If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** (Month, Day, Year) **Director** 215-10-1124 1 🔀 M 2 🗆 F 100 June 18, 1911 Maryland Usual Residence of Decedent ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at 10a. State 10b. County 10d. Inside City Limits 10c. City, Town or Location Director 1 Yes 2X No Baltimore Towson MD. 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1055 W. Joppa Rd. #319 USA 21204 death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Bace - American Indian med Forces?

Yes 2X No Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2x ☐ No Specify: Specify: White Completed 3 K Widowed 4 □ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working 2 should be filed within 72 h and Mental Hygiene. 7 is marked other than "r life, DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Engineering Executive Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Edward J. Funk Margaret Gocking Department of Health and Important: If item 27 is n. any injury or other traumone. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 676 Detamble Rd. Highland Park, Il. 60035 Edward Funk/ Son 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place, 1 Burial 2X Cremation 3 Removal from State 3-20-12 Towson, MD. 4 Donation 5 Other (Specify) <u> Hilltop Service Co.</u> 21. Signature of Fuveral Se 22. Name and Address of Facility RUCK Towson Funeral Home, 1050 York Rd. Towson, MD. ice Licens 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line. nterval Betweer Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter onderlying Cause (Disease or injury Due to (or as a consequence of): Exami the attending physician and hed for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Day Pregnant at time of death 5 Other (specify) ate has been signed by the a page 2 should be detached g Unknown Unknown death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No certificate has 2 No 1 Yes filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital Other: 2 XNO 1 Tes ဂ္ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 Residence 6 ☐ Other (Specify after death.

Director: After this 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred Natural (Month, Day, Year) 5 Pending 1 Yes 2 No Investigation Accident Suicide 6 Could not be 3 ☐ Suicide 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number 24 hours after o determined 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a Certifier within 24 hor To the Fune completely fi Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. only one Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Registrar

DHMH 17 Rev 06-2011

State

31. Date filed (Month, Day, Year)

MAR 20

OWSON MD

who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Jime of Death Day 2012 March 16. Dennis Ronald Freund 3:20 A 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Baltimore Gilchrist Hospice Towson 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) g. Birthplace (State or Foreign Min. Hours Country) 218-42-0636 1 X M 2 □ F 65 27. Mar. Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No Maryland Harford Havre de Grace 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21078 40 Robin Hood Road Lot 495 USA 12. Was Decedent Ever in U.S Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Armed Forces Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 1 No If Yes, Give 1 ☐ Yes 2X No Specify: 3 Widowed 4 Divorced Specify: White Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) Soap Manufacturer Millwright 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Eva (nmn) Schlesinger Adam John Freund 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21078 Yvonne G. Freund / Wife 40 Robin Hood Road, Lot 495, Havre de Grace, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) 4 ☐ Donation 5 ☐ Other (Specify) Rose Hill Svcs, LLC 3-19-12 Bel Air, Maryland McComas Funeral Home, P.A. 1317 Cokesbury Rd., Abingdon, 200 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final dsopwign disease or condition resulting in death) morotha Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to for as a consequence of Due to (or as a consequence of): resulting in death) Last 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? Month Day Year 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? MUSTAR 1 Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

Physician/ Medical Examiner Examine

Physician/

Medical

10a. State

Director

Funeral

þ

Completed

Be

൧

Examiner

Funeral

Director

show at

ms 23a or 28a-f s must be notified

ral", or items? death

"natural",

f Health and Mental Hygiene. item 27 is marked other than "natur other traumatic event, the Medical

permit. Page 1 a Department of H Important: If ite any injury or ot

or other traumatic

Maryland 21215-0036 and 2 should be filed within 72 hours after

Baltimore,

burial-transi Physician/Medical Completed by Be

IF FEMALE

attending physician for use as the buris death certificate be signed by the atter this certificate has Certificate: the

Division of Vital Records, P.O. Box 68760 within 24 hours after death. To the Funeral Director: After To the Hospital or Attending

10 kg

29b. Signature and title of certifier

5 Pending

Investigation

determined

6 Could not be

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 🗆 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29d. Date signed (Month, Day, Year) MNCH 16 2012

28f. Location (Street and Number or Rural Route Number, City or Town, State)

24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No

24a. Was an

26. Place of Death (Check only one)

Other:

1 ☐ Yes 2 ☐ No

28c. Injury at work?

autopsy performed?

4 Nursing Home 5 Residence 6 Other (Specify)

28d. Describe how injury occurred

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Hospital

28a. Date of injury

(Month, Day, Year)

I CHARLES MO C701 AANUN

1 Inpatient 2 ER/Outpatient 3 DOA

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28b. Time of

31. Date filed (Month, Day, Year) State Registrar MAR 2 0 2012

25. Was case referred to medica

2 X No

examiner?

1 Tyes

27. Manner of Death

1 Natural

Accident

3 Suicide 4 Homicide

29a. Certifier

DHMH 17 Rev 06-2011

		-	for State of Ma State Registrar	-	artment of Hea <i>tificate of Dea</i>		, ,	ene g. No. 🔿 🔘	1.0	00000		
	Discolata	_,	Decedent's Name (First, Middle, Last)				Date of Death Month	-	Year	3. Time of Death		
	Physicia Medic	al	Roxanne Froneberger				_	11, 2012 2340		2340 м		
	Examin	er	4a. Facility Name (if not institution, give street and number) Medstar Montgomery Medical	Center	4b. City, Town, or Loca Olney	ation of Death		4c. County of Death Montgomery				
200	Funeral		5. Social Security Number 6. Sex 7. Age	(In yrs. last birthday)	If Under 1 Year If U	Inder 24 Hrs.	8. Date of Birth		9. Birthp	ace (State or Foreign		
	Director		578-70-1962 1□M 2X□F	60 Yrs.	Months Days Ho	urs Min.	(Month, Day, 1 10–21–19		Count Nash.	*/		
	and show at	o	Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or Loc					10	d. Inside City Limits		
	Maryla 28a-f otified	Director	MD PG	Su	uitland					1X Yes 2 □ No		
	s 23a or	Funeral D	10e. Street and Number 4154 Suitland Rd.		10f. Zip Code 20746		10	ng. Citizen of V	Vhat Count JSA	ry?		
336	e filed within 72 hours after death with the Maryland tal Hygiene. ed other than "natural", or items 23a or 28a-f show ed other than batural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	by	11. Marital Status 1	0	Nas Decedent of Hispani f Yes, specify Cuban, Me I ☐ Yes 2 🌠 No Sp	exican, Puerto P	ify Yes or No- tican, etc.)	Blac	e - America k, White, e Blac	tc.		
Maryland 21215-0036	Phours natur dical I	Completed	15. Decedent's Education (Specify only highest grade completed)	16a. Deced	dent's Usual Occupation kind of work done during	most of workin	a 1	6b. Kind of Bu	ısiness/Ind	ustry		
121	I within 72 ygiene. h er than t, the Me	lmo	Elementary/Secondary (0-12) College (1-4 or 5+	ist. D	O NOT use retired)	777031 07 17 07 1117		. 514.	1_4_			
d 2	filed wil al Hygie d other	Be	17. Father's Name (First, Middle, Last)		Nurse 18.	Mother's Name	(First, Middle, Ma	t. Eliz aiden Surname		n		
/lan	should be file and Mental I 7 is marked o raumatic eve	임	Robert Lee Froneberger		ני	[helma	Le	е				
Mar	1 and 2 should be if Health and Men item 27 is marke other traumatic	7	19a. Informant's Name/Relationship (Type, Print) Yolanda Froneberger/Daughte:	T T	ng Address <i>(Street and N</i> Ast NE Was ł				tate, Zip C	ode)		
a)	1 and 2 s of Health item 27		20a. Method of Disposition	20b. Place of Dispo	sition (Name of			20c. Location -	City or Tov	vn, State		
mo	Page 1 nent of int: If i		1 ☐ Burial 2 🌠 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	cemetery, cren Riverdale	e Pk Crem.	3-20-2	2012	Riverda	ale, l	MD		
Baltimore,	permit. Page 1 a Department of H Important: If its any injury or of		21 Signature of Funeral Service License	-	Name and Address of I		nald Tay	lor II	FH	20695		
	23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.									Approximate Interval Between		
_	hysician/		Immediate Cause (Final disease or condition resulting in death) a. Due to (or as a consequence disease)									
	Medical Examiner		Due to (or as a									
		ner	Sequentially list conditions, if any, leading to in modiate									
	cuted nd transit	Examiner	cause, Enter Underlying Cause (Disease or injury that initiated events c									
	cate be executed physician and s the burial-transit	alE	resulting in death) Last Due to (or as a	consequence of):								
190		ledical	d									
Box 68	To the Hospital or Attending Physician: The law requires that the death certifics within 24 hours at er death. To the Funeral Director After this certificate has been signed by the attending p completely filled in by the funeral director, page 2 should be detached for use as		IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	Fetal death 3	Ectopic pregnancy Other (specify)			23d. Dat Mo	e of delive	ry Day Year		
P.O.	at the		9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but	t not resulting in the u	inderlying cause given in	Part I.	23e Did toba	acco use contr	ibute to the	e cause of death?		
S, P	ires th signe Id be o	d by								ably 4 o nknown		
ord	w requ	Completed					24a. Was an			sy findings available		
Rec	The law ate has page 2	Som					autopsy perform 1 Yes 2		death?	npletion of cause of 2 No		
tal	ysician: The s certificate director, pa	Be	25. Was case referred to medical examiner?		Othor	f Death (Check	only one)					
j Vi	Physi r this c eral dir	는 일:	1 ☐ Yes 2 ☐ No Hospital: 1 ☐ Inpatier 27. Manner of Death 28a. Date of injury	nt 2 ER/Outpatier 28b. Time of	nt 3 🗆 DOA 4		ne 5 Resider 8d. Describe hov					
o uc	Attending Phi or death. ector After thi by the funeral	icate	1 ☑ Natural 5 ☐ Pending (Month, Day, 2 ☐ AccidentInvestigation	Year) injury	work? M 1 ☐ Yes	_		,,				
Division of Vital Records,	I or Atten af er dea Director dir by th	Certificate:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e. Place of Injurbuilding, etc.	y - At home, farm, stre (Specify)	eet, factory, office	2	8f. Location (Stre City or Town,		er or Rural	Route Number,		
	To the Hospital or within 24 hours af To the Funeral Dir completely filled in	Medical	29a. Certifier 1 Certifying Physician: To the best of m						4.0	/ A 1 1 1 1		
	thin 24	Me	only one) 3 Certifying Nurse Practitioner: To the 29b. Signature and title of certifier	best of my knowledge,	death occurred at the tim	ne, date and place	ce, and due to the	cause(s) and m	nanner as si	ated.		
	5 ₩ E 00		29b. Signature and title of certifier	Med De	D0050	410	28	3/13/	12	u, rou/		
	JOBY		30. Name and address of person who completed cause of dea	ath (Item 23a) (Type, F	Pript) 11	<i>(</i>)	C/-	1	2 -			
	J ,		Michael Kerr MD	18101 1	one Phil	-p D-	Viney	MA	200	P\$ 7		
	Sta Registra		31. Date filed (Month, Day, Year) 32 Registrar	s signature	death occurred at the time 29c. License num 29c. License num 20c. License num 2num 2nu							

State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Mabel Μ Physician/ Gathagan March 15 2012 2012 1:26P Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 7730 Walter Road Anne Arundel Pasadena If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** Months Days Hours Min. oct. 28 West Virginia 235-14-8346 92 7919 **Director** 1 M 2 X F Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits aţ Director must be notified 1 Yes 2 No Maryland Anne Arundel Pasadena 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? ö 23a Funeral 7730 Walter Road 21122 USA death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? 14. Race - American Indian 11. Marital Status Examiner Black, White, etc. ö þ 1 Never Married 2 Married 1 Yes 2 X No If Yes, Give Year or Dates. Baltimore, Maryland 21215-0036 Page 1 and 2 should be filed within 72 hours after 1 ☐ Yes 2 No Specify: Specify. white "natural", Completed 3 Midowed 4 Divorced the Medical 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed, (Give kind of work done during most of working life. DO NOT use retired) I Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) homemaker household traumatic event. Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental F ပ Albert Ida Mae Brown Russ 9b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7730 Walter Road Pasadena MD 21122 19a. Informant's Name/Relationship (Type, Print) Carolyn Gathagan daughter f Health item 27 other 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date Department of Important: If it any injury or o ☐ Burial 2 Cremation 3 ☐ Removal from State Metro Crematory Inc 3/17/2012 ■ Donation 5 ☐ Other (Specify) Baltimore MD 22. Name and Address of Facility Stallings Funeral Home P.A. 21. Sign of Funera 3111 Mountain Road Pasadena MD 21122 at caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest 23a. Part 1. Enter the di Part 1. Enter the disease, or complice shock, or heart failure. List only one Approximate Onset and Death Immediate Cause (Final Ph_sician/ atrial fibrillation disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of): attending physician and for use as the burial-transit Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 XNo Day Pregnant at time of death 5 Other (specify) the detached Unknown ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🔀 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has by page 2 s performed? Yes 2 Ko 1 Yes 2 No the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital 2 **X**No Other: ၉ 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 K Residence 6 Other (Specify) 28a. Date of injury 28b. Time of 27. Manner of Death Certificate: 28c. Injury at 28d. Describe how injury occurred after death. Director; After 1 Natural (Month, Day, Year) injury work? 1 ☐ Yes 2 ☐ No 5 Pending M Investigation Accident Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number filled in by 4 Homicide determined within 24 hours a Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 3/19/2012 DG3726 Name and address of person who completed cause of death (Item 23a) (Type, Print) 1406 Crain Highway Glen Burnie MD 210 more oslan. Kunni 21061 State Registrar

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760

				se Type or F					-	•	gible.	
	-	For State Registrar	mend Ite	state of 23aPt1	,25,27	,28a-f	per me tilicate of l	g 925,037 : Death	2072012	Reg. No.	112 08	511
Physicia		1. Decedent's Nam		·	+ia				2. Date of Do	eath Day	3. Time of	Death M
Medic Examin		4a. Facility Name (if	not institution, g	s Guberna	er)	+1	4b. City, Town, o	r Location of Deatl		4c. County		101
Funeral		5. Social Security N		. Sex 7.	Age (In yrs.	last birthday)	If Under 1 Year	If Under 24 Hrs.		rth	Birthplace (State of the control of the contro	r Foreign
Director		218-44-13 Usual Residence of	7 mm	1 X M 2 □ F	66_	Yrs.	Months Days	Hours Min.	June 3	1945	Country) Mary	Land
s after death with the Maryland ral", or items 23a or 28a-f show Examiner must be notified at	Director	10a. State	10b. County	_		ty, Town or Loc	cation				10d. Inside Ci	ty Limits
filed within 72 hours after death with the Maryland al Hygiene. d other than "natural", or items 23a or 28a-f sho vent, the Medical Examiner must be notified at		Mary Land 10e. Street and Nur	Harfo	rd	Ab	ingdon	10f. Zip Code			10g. Citizen of		2265 110
ath witl	Funeral	2102 Nic	ole Way	12. Was Decede	ent Ever in 11	S 13 V	21009	lispanic Origin? (Sp	necify Yes or No	USA	ce - American Indian,	
after de I", or ite camine	۵	1 Never Marr		Armed Force	es?	If	f Yes, specify Cuba	an, Mexican, Puerti	o Rican, etc.)		ck, White, etc.	
2 hours a "natural" edical Ex	Completed	3 Widowed	15. Decedent's	Year or Date s Education	s.	16a. Deced	lent's Usual Occup	ation			White usiness Industry	
thin 72 ene. than " he Mec	ğ	Elementary/Sec		College (1-4	or 5+)	life. DO	kind of work done of NOT use retired)		rking			
filed will Hygid d other went, t	Be	17. Father's Name (First, Middle, Las	4 4 st)		_ spec.	tat tiives		me (First, Middle	, Maiden Surnam	<u>Electric Co</u>	•
should be and Ment is marked raumatic e	욘	Louis Ch		ubernatis				l	Mary Bob			1
and 2 sho Health an Health ar em 27 is ther trau			·	bernatis	/ Wife		_	and Number or Ru Vay, Abir			State, Zip Code)	
Page 1 ar ment of He ant: If iter ury or oth			Cremation 3	Removal from St	tate	emetery, crem	sition (Name of natory or other place	· i	Date		- City or Town, State	
permit. Page 1 and 2 should be filed within 72 hours Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical I once.		21. Signature of Pur	5 Other (Speneral Service Lice		Cro		le Vet. (sem. 3-2 uneral H	20-12		ville, Mary	<u> Land</u>
9 9 E 9 9	-	23a Part 1 Enter t	he disease or co	omplications that cau	Add		1317 Coke	esbury Ro	l Abın	adon. Mi	21009 Approximate	
Physician/		shock, or hear Immediate Cause (disease or condition	rt failure. List onl Final	y one cause on each	seps	sis		g, ouen de eardide	or roop, atory a	PPROPER NEWCH	Approximate Interval Between Interval Betwe	ween
Medical Examiner		resulting in death)		Due to (or	as a consequ	uence of):	Filmo	0	Marco	TOWED BY WEDILL	ba	45
- t	niner	Sequentially list co if any, leading to in cause. Enter Under	nmediate	b. Due to (or	as a consequ	uence of):		T .	THORNON	Value .	5	LYS_
executed an and ial-transi	Examiner	Cause (Disease or that initiated events resulting in death)!	s í	,	as a consequ	,	Fon	allon	GEW.		Da	45
	edical		•	d. Po	1ypect	сошу						
ath certificate be attending physici for use as the bu	an/M	IF FEMALE: 23b. Was decedent in the past 12 r		23c. If yes, outco			Ectopic pregnanc	CV		23d. Da	ate of delivery	
the deat by the att tached fo	Completed by Physician/Medica	1 Yes 2 Unknown	No		nt at time of		Other (specify) _	·		Mo	onth Day Y	'ear
v requires that to been signed be should be dete	by P			s contributing to dea		4	. /	ven in Part I.	1		gibute to the cause of do	
w requir s been s	oletec	, -		byslip	1 4			31eodin	24a. Was	an 24b.	Were autopsy findings a	vailable
sician: The law I certificate has k irector, page 2 s				70.1.7					auto	ormed2	prior to completion of cadeath? 1 Yes 2 No	ause of
Physician this certif ral directo	To Be	25. Was case referre examiner? 1 2 Yes 2 E	no medical	Hospital:	patient 2 🗆	ER/Outpatien	Oth	ace of Death (Checer: 4 Nursing H		dence 6 🗆 Oth	er (Specify)	
iding Pt th. After th funeral		27. Manner of Death T	n 5 ☐ Pending Investigat	28a. Date of		28b. Time of Unknow	28c. Injury	y at	28d. Describe Colon Pe	how injury occurrer		
or Attending Physician: The law requires that the death certificate be after death. Director: After this certificate has been signed by the attending physici in by the funeral director, page 2 should be detached for use as the bu	Certificate:	3 Suicide 4 Homicide	6 Could no determine	t be 28e. Place of building	Injury - At ho , etc. <i>(Specif</i> y	1) . 5	et, factory, office		28f. Location (City or To		er or Rural Route Numb Loch Rave	er,
	Medical (Hospi hysician: To the bes	t of my know	ledge, death o			Blvd., and due to the ca	Baltimor ause(s) and mann	e,MD er as stated.	
o the H vithin 24 o the F			Certifying N	urse Practioner: To	the best of m	y knowledge, d	leath occurred at the	e time, date and pla	at the time, date ace, and due to the	ne cause(s) and m	e to the cause(s) and mar anner as stated. d (Month, Day, Year)	iner stated.
ا کرائیت		> L	you .	plyc	4		P	ES 000	3	March 1		
012		30. Name and addre	ess of person whe	o completed cause of	of death (Item		rint) Bala	timore	, MI	D		
State Registra	.	31. Date filed (Monti		1 2	istrar's Signa				-			
IMH 17 Rev 7/200			AR 2 0 2	VIL Serve	we p	9. Au	What .					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Physician/ 5:46 PM Gra 2012 Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number, 4b. City, Town, or Location of Death **Examiner** of N/A Baltimore City yland If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, 9. Birthplace (State or Foreign Number 7. Age (In yrs. last birthday) **Funeral** Hours Months Days MD 1 🗆 M 2 💆 F 56 Director 219-64-9300 Mar 18, 1955 Yrs or 28a-f show 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State item 27 is marked other than "natural", or items 23a or 28a-f sho other traumatic event, the Medical Examiner must be notified at Director 1 Yes 2 No **Baltimore** Anne Arundel MD 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number Funeral U.S.A. 21225 301 Bridgeview Road Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces?

1 Yes 2 No
If Yes, Give Black, White, etc. ģ 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 No Specify: Black Specify: 3 Widowed 4 Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Il Hygiene. College (1-4 or 5+) Elementary/Secondary (0-12) Maryland Corrections Record Keeper 12 Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) permit. Page 1 and 2 should be file.
Department of Health and Mental H.
Important: If item 27 is marked any injury or other. ဂ Jean Froneberger **Edward Stanley** 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Baltimore, MD 21225 301 Bridgeview Road, Kenesha Gray Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State Lansdowne, Maryland Mar 21, 2012 Mt. Zion Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility

Estep Brothers Funeral Service, P. A.
1300 Eutaw Place Baltimore, Md 21217 Signifure of Funeral Service Licerisee 23a. Part 1. Oper the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Approximate Interval Between Onset and Death Immediate Cause (Final Ph_sician/ -on 1854 IVE disease or condition resulting in death) Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or injury page 2 should be detached for use as the burial-tran and that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 mo ths?
1 ☐ Yes 2 ☑ No Month Day Year Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Division of Vital Records, 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 1 Yes 26. Place of Death (Check only one) 25. Was case referred to medical Other: 2 No 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) ဂ the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b Time of 28c. Injury at 28d. Describe how injury occurred Certificate: Natural 5 Pending 1 🗌 Yes 2 🗌 No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined e Funeral E Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier completely 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one within 2 29b. Signature and title of certifier

State Registrar and address of person who completed cause of death (Item 23a) (Type, Print)

2012

21201

		_ For	se Type or State o		nd / Dep	artment	of He	ealth a		II Copie Iental Hy		_	jible.	
Physicia		1 - State Registrar 1. Decedent's Name (First, Middle Edward	Last) ELAdi	Low 9		rtificate	of De	eath		2. Date of De	Reg. No	• 2 <u>0</u>	Year Year	3. Time of Death
Medic Examin	er	4a. Facility Name (if not institution, Holly Hill Nursi:	give street and num	abilita	tion	4b. City, T	Tows						of Death	ore
Funeral Director		5. Social Security Number 212 09 0730 Usual Residence of Decedent	6. Sex 1	7. Age (In yrs. 98	Yrs.	Months	Days	Hours	Min.	8. Date of Bir (Month, Da June 5,	191 191	3	Ma:	place (State or Foreign try) cyland
Maryland 28a-f sho notified at	Funeral Director	-	imore	10c. Ci	ty, Town or Lo	ex								0d. Inside City Limits 1 Yes 2 K No
h with the ns 23a or must be	neral [329 Upperlandi				10f. Zip (2122					USA		
permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	by	11. Marital Status 1 ☐ Never Married 2 ☐ Mari 3 ☒ Widowed 4 ☐ Divorced	ried Armed Fo 1 Yes If Yes, Giv Year or Da	2 🔀 No e		Was Decede If Yes, specif 1 Yes 2	y Cuban,	Mexican	gin? (Spe , Puerto i	cify Yes or No- Rican, etc.)		Blac	e - Americ ck, White, Whi	etc.
within 72 hor giene. e r than "nat , the Medics	Completed	15. Deceder (Specify only higher Elementary/Seconday (0-12) 12	nt's Education est grade completed College (1	-4 or 5+)	(Give life. E	dent's Usual kind of work 100 NOT use i ner/Op	done du etired)	ring most	of worki	ng			usiness tre Shop	
ld be filed v Mental Hyg arked oth atic event,	To Be	17. Father's Name <i>(First, Middle, L</i> Felix Gladkowsk								e (First, Middle, ca Sobo		Sumame	е)	
od 2 shoul salth and n 27 is m er traum:		19a. Informant's Name/Relations Susan Galicki (Route Numbe Stminst				
Page 1 ar nent of He ant: If iter ıry or oth		20a. Method of Disposition 1 ☒ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (S		01.1.	Place of Dispo cemetery, cre Stani:	natory or off	ner placel	tery		Date /2012			City or To	wn, State Iaryland
permit. Departr Imports any inji		21. Signature of Funeral Service L	icensee	?	2 1	2. Name and TUZOZ 407 O	Address inski ld Ea	of Facility i Fur aster	neral m Av	l Home Venue E	P.A.	k, Ma	ıryla	nd 21221
Physician/ Medical		23a. Part 1. Enter the disease, or shock, or heart failure. List of Immediate Cause (Final disease or condition resulting in death)	a.	ch line.	eac			1			rrest,			Approximate Interval Between Onset and Death
Examiner	iner	Sequentially list conditions, if any, leading to immediate	b. Due to	or as a conseq	quence of):					_				
oe executed ician and ourial-transit	al Examiner:	cause. Enter Underlying Cause (Disease or linjury that initiated events resulting in death) Last	c. Due to	or as a conseq	quence of):									
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-trans.	by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown		Birth 2 Tet nant at time of	tal death 3	☐ Ectopic pr ☐ Other (spe							ate of deliver	ery Day Year
requires that the de been signed by the should be detached	ted by Ph	Part II. Other significant condition	ons contributing to d	eath but not re	sulting in the	underlying ca	ause give	n in Part I	l.	23e. Did t		_		ne cause of death?
sician: The law re certificate has be lirector, page 2 sho	Completed									24a. Was auto perfo 1 \square Yes	psy ormed?		Were auto prior to co death? 1 □ Yes	psy findings available mpletion of cause of 2 No
nysician: nis certifi I director	To Be	25. Was case referred to medical examiner? 1 Yes 2 No	Hospital:	Inpatient 2] ER/Outpatie	nt_3 🗆 D0/	Other			on <i>ly</i> one) me 5 🗆 Resi	dence	6 🗆 Othe	er (Specify)
ending Pl sath. or: After the	Certificate:	27. Manner of Death 1 Natural 5 Pendir 2 Accident Investi	gation	of injury th, Day, Year)	28b. Time o injury	f 28	c. Injury a work? 1 \Bar Y		- 1	28d. Describe l	how inju	ry occurr	ed	
To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completed filled in by the funeral director.		3	inod 28e. Place	of Injury - At h ng, etc. <i>(Specit</i>		reet, factory,	office			28f. Location (City or Tov			er or Rural	Route Number,
the Hospi nin 24 hou the Funer	Medical	29a. Certifier 1 Certifying (Check 2 Medical E only one) 3 Certifying	Physician: To the back examiner: On the back Nurse Practioner:	est of my know sis of examination To the best of m	vledge, death on and/or inves ny knowledge,	occured at the stigation, in made ath occurrence of the street occurrence occ	ne time, only opinion at the f	date and p , death oc time, date	place, an ccurred at and place	d due to the ca the time, date a e, and due to the	ause(s) a and plac ne cause	ind manne, e, and due (s) and ma	er as state e to the ca anner as st	d. use(s) and manner stated. ated.
To with		29b. Signature and title of certifier	1000	an	121	4	License r		70	2		-	d (Month, 1	•
Jeh,		30. Name and address of person	who completed caus	se of death (Iter	m (Ba) (Type,	Print)	- 1	9/v	10	Hen	Ba	RH	ipi	2012
Stat	е	31. Date filed (Month, Day, Year)	. 32. F	egistrar's Signa	ature								(

Registrar

DHMH 17 Rev 7/2009

Server S. forces

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death March 17, 2012 Physician/ Judith Ann Griffin 11:27 p^M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 3651 Morningview Court Ellicott City Howard Social Security Number 8. Date of Birth (Month, Day, Year) 6. Sex If Under 24 Hrs Birthplace (State or Foreign Country) **Funeral** 7. Age (In yrs. last birthday) If Under 1 Year 217-40-4252 **Director** 1 M 2 X F 70 Feb. 1942 Maryland 3, Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy rigiury or other traumatic event, the Medical Examiner must he arrived once. 10a. State 10b. County 10c. City, Town or Location Director MD Howard Ellicott City 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? Funeral 3651 Morningview Court 21042 USA 12. Was Decedent Ever in U.S. Armed Forces? . Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Married Completed by 1 Yes If Yes, Give 2 XNo Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2 🖾 No Specify: Specify 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) Medical Transcriptionist Medical Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Gilbert Thompson Mildred Margraf 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
3651 Morningview Court; Ellicott City, MD 21042 Stanley Griffin Husband 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place)
Atlantic Crematory 1 Burial 2 K Cremation 3 Removal from State 3/20/2012 Glen Burnie, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Sterling Ashton Schwab Witzke Funeral Home of Catonsville, Inc. 21228 <u>.630 Edmondson Avenue: Catonsville</u> 23a. Part 1. Enter the disease complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death Physician/ Metastano Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) Cause (Disease or injury that initiated events resulting in death) Last To the Hospital or Attending Physician: The law requires that the death certificate be executed the burial-trai Due to (or as a consequence of) attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months? Month Day Year Pregnant at time of death 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has page 2 autopsy performe death? Yes the funeral director, 25. Was case referred to medical To Be 26. Place of Death (Check only one) Other: 4 \(\text{Nursing Home} \) 1 Residence 6 \(\text{Other} \) Other (Specify) 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 27 Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 X Natural work' s after death. 1 Yes Investigation 6 Could not be 2 🗌 No Accident Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 28f. Location (Street and Number or Rural Route Number, 4 Homicide City or Town, State) 24 hours Funeral I Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. completely (Check within 2 To the I only one) 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) 2012 195 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar
DHMH 17 Rev 06-2011

State

Sastry

ejaswi Sa ate filed (Month, Day,

MAR 2 0 2012

32. Registrar's Signature

10710 Charter Dr., Suite Gozo

Columbia.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Milton G. Hyde March 2012 08:10 AM 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Tate Hospice House Linthicum Anne Arundel 5. Social Security Number If Under 1 Year If Under 24 Hrs 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 219-30-2160 1 XM 2 □ F 82 Yrs. Maryland May 28 1929 Usual Residence of Decedent 10c. City, Town or Location Pasadena 10d. Inside City Limits Maryland Anne Arundel 1 Yes 2 No 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? 1695 Grandview Road 21122 USA 11. Marital Status 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Married 1 ▼ Yes 2 □ No If Yes, Give Year or Dates. 1 Yes 2 No Specify. white 3 Divorced 4 Divorced Specify: 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) manager manufacturing 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Milton Marie Neussinger Hyde 19a. Informant's Name/Relationship (Type, Print) Katherine Hyde 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) spouse 1695 Grandview Road Pasadena MD 21122 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 🔀 Burial 2 🗌 Cremation 3 🗌 Removal from State 3/24/2012 Pasadena Maryland 4 ☐ Donation 5 ☐ Other (Specify) Mt Carmel Cemetery 21. Signatu 22. Name and Address of Facility Stallings Funeral Home P.A. 3111 Mountain Road Pasadena MD 21122 23a. Part 1. Enter the disease, or o shock, or heart failure. List or hat caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Onset and Death Immediate Cause (Final STA GE disease or condition resulting in death) PUMONARY Combination of pulmona Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) that initiated events resulting in death) Last Due to (or as a consequence of): 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 3 Ectopic pregnancy 5 Other (specify) IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? Month Day Year 1 Yes 2 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Hyperrensive Cardiovascular disease with 1 ☐ Yes 2 🔀 No 3 ☐ Probably 4 ☐ Unknown atheric Fibrillation and COR pulmonale 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performe 1 Yes 2 No Yes 2 X No 25. Was case referred to medical examiner?

Physician Medical Examiner

Physician/

Examiner

Funeral Director

> 28a-f show notified at

ō

9

"natural",

2 should be filed within 72 th and Mental Hygiene.

Baltimore, Maryland 21215-0036

ms 23a or must be n

Examiner

Medical

the

other traumatic

permit. Page 1 and 2 sh
Department of Health ar
Important: If item 27 is
any injury or other trau

Medical

Director

Funeral

þ

Completed

Be

ပ

Examine Physician/Medical Completed by

Be

မ

Certificate:

1 Yes 2 No

5 Pending

27. Manner of Death

1 🗷 Natural

☐ Accident☐ Suicide

4 Homicide

physician and s the burial-trans attending ph ed by the a detached 1 r signed by t. Id be detach page 2

Hospital or Attending Physician: The law requires that the death certificate be executed

After this certificate has

Division of Vital Records, P.O. Box 68760

within 24 hours after death

To the Funeral Director;

completely filled in by the Medical Registrar

				20.114000	n Death (enc	ON ON	y one,		
05	spital: 1 lnpatient 2	ER/Outpatient	3 🗆 DOA	Other: 4	☐ Nursing ⊢	łome	5 Residence	6	Other (
	28a. Date of injury (Month, Day, Year)	28b. Time of injury	28c	. Injury at work? 1 ☐ Yes	2 🗆 No	28d.	. Describe how in	jury occ	urred

Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office determined building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Dice,

29a. Certifier 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifier

who completed cause of death (Item 23a) (Type, Print)

MARTINEZ, MD 2932 A MOUNTAIN ROAD PASADENA DRANA MARIA

37229

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Donald Thomas Hadden 2012 March Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Newburg <u>10570 Crain Highway</u> Charles If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) **Funeral** Months Min 209-24-1697 **Director** 1 X M 2 □ F 78 Yrs. Jan 19, 1934 Pennsylavania 28a-f show be filed within 72 hours after death with the Maryland 10b. County 10c. City, Town or Location Examiner must be notified at **Funeral Director** 1 Yes 2 No Newburg Maryland Charles 9 10e. Street and Number 10g. Citizen of What Country? items 23a 20664 **USA** 10570 Crain Highway 12. Was Decedent Ever in U.S. Armed Forces?

1 X Yes 2 No 1949
If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. "natural", or Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🎇 No Specify: Specify: White 3 Widowed 4 Divorced 1954 Year or Dates traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) other than Elementary/Secondary (0-12) 10 College (1-4 or 5+) Master Plumber Plumbing Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) it. Page 1 and 2 should be filer trment of Health and Mental H rtant: If item 27 is marked of njury or other traumatic ever 2 Michael Myers Lilly Pearl Staley 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>Deanna Joan Hadden, Wife</u> 10570 Crain Highway Newburg, Marvland 20664 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1 a Department of H Important: If ite any injury or ot Date 1 Burial 2 X Cremation 3 Removal from State cemetery, crematory or other place) 4 Donation 5 Other (Specify) 03/19/12 Metro Crematory Inc. Baltimore, Maryland Signature of Funeral Service Lice Se Thomas Gregor Name and Address of Facility
emation Society Of Maryland,
9 Frederick Road Baltimore, Maryland 21228 23a. Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line, Interval Between Onset and Death Immediate Cause (Final Physician eu scon disease or condition Medical resulting in death) Due to (or **Examiner** Sequentially list conditions Examiner if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events Due to (or as cellow Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No 3 Ectopic pregnancy Month Pregnant at time of death 5 Other (specify) Day 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? page 2 autopsy perform Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 2 No Hospital Certificate: To 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of I Director: After the in by the funeral 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 Yes Investigation Accident Suicide Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined within 24 hours a

To the Funeral C

completely filled Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated | Certifying Nurse Practition | To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 29b. Signature and title of certifie 29d. Date signed (Mon201/2) ear) ddress of person who completed cause of death (Item 23a) (Type, Print) Rults 208A, Walter mu) 3460, 010 SEIN Mins

DHMH 17 Rev 06-2011

Registrar

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Mont Physician/ Holston III 12:10 AM Warren 2012 March Medical 4a. Facility Name (if not institution, give street and number) 4b, City, Town, or Location of Death 4c. County of Death **Examiner** Tate House Linthicum Anne Arundel 5. Social Security Number 6. Sex If Under 1 Year Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) If Under 24 Hrs 8. Date of Birth **Funeral** (Month, Day, Year) 217-72-5142 **Director** 1 🛛 M 2 🗆 F 52 Yrs Aug. 11, 1959 Maryland Usual Residence of Decedent 28a-f show 10a. State 10b, County 10c. City, Town or Location 10d. Inside City Limits Director əms 23a or 28a-f sh r must be notified a 1 Yes 2X No Cambridge Maryland Dorchester 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21613 5228 Woods Road, Apt. 2137 United States items 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Armed Forces?

1 XYes 2 No
If Yes, Give
Year or Dates. Black, White, etc. ö q 1 Never Married 2 Married than "natural", he Medical Exar 1 ☐ Yes 2 XNo Specify. White Specify: 3 Widowed 4 XDivorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Disabled N/A and Mental Hygier is marked other t Be permit. Page 1 and 2 should be filed.
Department of Health and Mental Hv. Important; if item 27 is marken any injury or other. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Elenora Peltz Thomas Holston 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7900 Benesch Circle, Apt. 803, Glen Burnie, MD 21060 Elenora Croissant / Mother 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 🗆 Burial 2 [XCremation 3 🗆 Removal from State Metro Crematory Inc. | 03/16/2012 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Alyson 22. Name and Address of Facility Cremation Society of Maryland Inc 299 Frederick Road, Baltimore, Maryland 21228 23a. Part 1. Enter the disease, or complicati from it caused shock, or he in failure. List only one cause on each line. In tale caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Immediate Cause (Final Physician/ Cuncer. disease or condition resulting in death) Medical Due to (or as a consequence of): **Examiner** if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Due to (or as a consequence of) Due to (or as a consequence of) resulting in death) Last Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ 1 Live Birth 2 Fetal deat
4 Pregnant at time of death
9 Unknown in the past 12 months?

1 Yes 2 No Month Day Year 1 ☐ Yes 2 ☐ 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe

To the Hospital or Attending Physician; The law requires that the death certificate be executed Box 68760 P.O. Division of Vital Records, after death.

Baltimore, Maryland 21215-0036

24 hours within 24 hor To the Fune completely fi

State

Certificate: To Be

Medical

25. Was case referred to medical

530

MAR 2 0 2012

5 Pending

Investigation Could not be

determined

examiner?
1 Yes 2 No

27. Manger of Death

▼ Natural

Accident

Suicide

☐ Homicide

29a. Certifier

(Check

1 Inpatient 2 ER/Outpatient 3 DDA

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

ause of death (Item 23a) (Type, Print

28h Time of

28a. Date of injury (Month, Day, Year)

26. Place of Death (Check only one)

2 No

28c. Injury at

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

work?
1 Yes

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

4 Nursing Home 5 Residence 6

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 20 | 2 For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Dennis S. Holm 2012 March 5:28 P ^M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Tate Hospice House Linthicum Anne Arundel 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** 8. Date of Birth Birthplace (State or Foreign Country) Months (Month, Day, Year) Hours Director 214-44-0552 sual Residence of Decedent 1 💢 M 2 🗆 F 66 Yrs. June 12, 1945 Maryland 28a-f show and 2 should be filed within 72 hours after death with the Maryland Health and Mental Hygiene. Health and Mental Hygiene. tem 27 is marked other than "natural", or items 23a or 28a-1 show ther traunatic event, the Medical Examiner must be notified at 10a. State 10b County 10c. City, Town or Location Director 10d. Inside City Limits Halethorpe 1 🗌 Yes 2 💢 No Maryland Baltimore 10e, Street and Number 10f. Zip Code 10g, Citizen of What Country? Funeral 2810 Manoff Road 21227 **USA** 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces?

1 X Yes 2 No 1964 Black, White, etc. Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: 3 Widowed 4 X Divorced Specify: White 1968 Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Secondary (0-12) Sales Furniture Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Leonard Fred Holm Sylvia Sofia Wiitala 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Fay H. Kujawa, Sister 1560 E Catasauqua Road Bethlehem, PA 18017 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Department of H Important: If ite any injury or ot 1 Burial 2 Kremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory Inc. 03/19/12 Baltimore, Maryland Signature of Funeral Service Ocensee Thomas Gregor Cremation Society Of Maryland, Inc. 299 Frederick Road Baltimore, Maryland 21228 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onsevand Death Immediate Cause (Final and Death Ph. sician disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cauce. E. iter concerning Cause (Disease or injury Physician/Medical Examiner Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months? 5 Other (specify) Month Pregnant at time of death 1 Yes 2 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Be Completed by 23e. Did tobacco use contribute to the cause of death? 1 Tes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed death? 1 🗌 Yes 2 🗌 No 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) 1 ☐ Yes 2 No Other: ျ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence Hospice 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work? 2 No Accident Investigation hin 24 hours after death the Funeral Director: Suicide Could not be 3 ☐ Suicide 4 ☐ Homicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within To the 29b. Signature At title of certifier 29d. Date signed (Month, Day, Year) cause of death (Item 23a) (Type, Print) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ MARCH Conrad Francis Heidel 5:00 P.M. 2012 Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** FRANKLIN SQUARE HOSPITAL BALTIMORE ROSEDALE If Under 1 Year If Under 24 Hrs 5. Social Security Number 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Hours **Director** 1**X** M 2 □ F 213-32-4165 01/13/1936 Maryland 76 ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Maryland Baltimore Essex 1 Yes 2XXNo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 209 Southeastern Terrace 21221 U.S.A. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-Was Decedent Ever in U.S. 11. Marital Status Race - American Indian. Armed Forces?

1007

1007

1007

1007

1007

1007

1007

1007

1007

1007

1007

1007

1007

1007

1007

1007

1007

1007

1007

1007

1007

1007

1007

1007

1007

1007

1007

1007

1007

1007

1007

1007

1007

1007

1007

1007

1007

1007

1007

1007

1007

1007

1007

1007

1007

1007

1007

1007

1007

1007

1007

1007

1007

1007

1007

1007

1007

1007

1007

1007

1007

1007

1007

1007

1007

1007

1007

1007

1007

1007

1007

1007

1007

1007

1007

1007

1007

1007

1007

1007

1007

1007

1007

1007

1007

1007

1007

1007

1007

1007

1007

1007

1007

1007

1007

1007

1007

1007

1007

1007

1007

1007

1007

1007

1007

1007

1007

1007

1007

1007

1007

1007

1007

1007

1007

1007

1007

1007

1007

1007

1007

1007

1007

1007

1007

1007

1007

1007

1007

1007

1007

1007

1007

1007

1007

1007

1007

1007

1007

1007

1007

1007

1007

1007

1007

1007

1007

1007

1007

1007

1007

1007

1007

1007

1007

1007

1007

1007

1007

1007

1007

1007

1007

1007

1007

1007

1007

1007

1007

1007

1007

1007

1007

1007

1007

1007

1007

1007

1007

1007

1007

1007

1007

1007

1007

1007

1007

1007

1007

1007

1007

1007

1007

1007

1007

1007

1007

1007

1007

1007

1007

1007

1007

1007

1007

1007

1007

1007

1007

1007

1007

1007

1007

1007

1007

1007

1007

1007

1007

1007

1007

1007

1007

1007

1007

1007

1007

1007

1007

1007

1007

1007

1007

1007

1007

1007

1007

1007

1007

1007

1007

1007

1007

1007

1007

1007

1007

1007

1007

1007

1007

1007

1007

1007

1007

1007

1007

1007

1007

1007

1007

1007

1007

1007

1007

1007

1007

1007

1007

1007

1007

1007

1007

1007

1007

1007

1007

1007

1007

1007

1007

1007

1007

1007

1007

1007

1007

1007

1007

1007

1007

1007

1007

1007

1007

1007

1007

1007

1007

1007

1007

1007

1007

1007

1007

1007

1007

1007

1007

1007

1007

1007

1007

1007

1007

1007

1007

1007

1007

1007

1007

1007

1007

1007

1007

1007

1007

1007

1007

1007

1007

1007

1007

1007

1007

1007

1007

1007

100 If Yes, specify Cuban, Mexican, Puerto Rican, etc. Black, White, etc. 1 Never Married 2 Married þ HEIDEL, CCNRADBaltimore, Maryland 21215-0036 1 ☐ Yes 2 🗷 No Specify: 3 Widowed 4 Divorced Specify: White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than 'any injury or other traumatic event, the Me Elementary/Secondary (0-12) College (1-4 or 5+) Electric Foreman 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Egenhofer William Fredrick Heidel Anna Margaret 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 209 Southeastern Terrace, Baltimore, Maryland 21221 Arlene Elizabeth Heidel (Wife) 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State Holly Hill Mem. Gard. 03/21/2012 4 ☐ Donation 5 ☐ Other (Specify) Baltimore, Maryland 22. Name and Address of Facility nski Funeral Home, P.A 1407 Old Eastern Avenue, Essex, Maryland 21221 enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, 23a. Part L Approximate Interval Between Onset and Death k, or heart failure. List only one cause on each line. mediate Cause (Final ase or condition Ph_sician/ NEUMONIA di ase or conum re ulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): Cause (Disease or Injury that initiated events resulting in death) Last the burial-tran Due to (or as a consequence of): attending physician Physician/Medical that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 months? Month Day Pregnant at time of death 1 Yes 2 No 9 Unknown þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by To the Hospital or Attending Physician: The law requires the within 24 hours after death.

To the Tuneral Director: After this certificate has been sign completely filled in by the funeral director, page 2 should be 2 No 3 Probably 4 Unknown 1 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy Yes 2 N 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be 2 No Hospital: Other: ၉ 1 Tes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28b. Time of 28d. Describe how injury occurred injury 1 Natural 5 Pending Accident Investigation M 6 Could not be Suici**d**e 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 1 🔏 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) & Janvier, MO, PhD

Registrar DHMH 17 Rev 06-2011

State

adven

31. Date filed (Month, Day, Year)

MAR 2 0 2012

30. Name and address of person who completed cause of death (Item 23a) (Type, Print).

ADRIEN L. JANVIER, MD. 9000 FRANKLIN SQUARE DR. BALTIMORE, MD. 21236

70158

MARCH 18, 2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 2. Date of Death Decedent's Name (First Middle, Last) **Physician** /Medical Facility Name (If not institution, give 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Johns Hopkins Bayview Medical Center **Baltimore** 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month Day, Year)

June 12, 1915 9. Birthplace (State or Foreign 6. Sex 7. Age (In vrs. last birthday) **Funeral** Months New York, NY 1 🗆 M 2 💢 F 093-07-3358 96 Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits MD Director Baltimore Timonium 1 ☐ Yes 2 XNo 10e, Street and Number 10f. Zip-Code 10g. Citizen of What Country? 510 Whithorn Court United States Funera Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc 1 Never Married 2 Married ☐ Yes Yes, Give 2X No 1 ☐ Yes 2 No Specify Specify: White ģ 3 X Widowed 4 □ Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Own Home Elementary/Secondary (0-12) College (1-4 or 5+) Homemaker 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Frank Vairo Grace D'Andrea ည 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Regina Brown- Daughter 510 Whithorn Court Timonium, MD 21093 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20b. Place of Disposition (Name or cemetary, cremator or other place)
Garrison Forest
Veterans Cemetery

22. Name and Address of Facility
Evans Funeral March 27, 1

Burial 2

Cremation 3

Removal from State 4

Donation 5

Other (Specify) Owings Mills, MD 2012 nsee 21. Signature Service Lia Chapel & Cremation Services 8800 Harford Rd. Parkville, MD or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, 23a. Part 1. Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause Final disease or condition resulting in death) Physician /Medical ue to (or as a consequence of). **Examiner** Secupertially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) or Attending Physician: The law requires that the death certificate be executed burial-trar that initiated events resulting in death) Last Due to (or as a consequence of) Box 68760, by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant ☐ Live birth 2 ☐ Fetal dea ☐ Pregnant at time of death in the past 12 months?
1 Yes 2 No 3 - Ectopic pregnancy Month Day Year 5 Other (specify) Division of Vital Records, P.O. 9 Unknown 9 Unkr Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? signed to 1 Tyes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 1 Tes 2 🗌 No certificate 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital: 1 ☐ Inpatient Other: 4 \sum Nursing Home 2 No Yes ER/Outpatient 3 DOA 5 ☐ Residence 6 ☐ Other (Specify) မ this Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Certification: After Natural 5 Pending investigation Injury 1 🗌 Yes 2 No eral Director; Af Accident hours after death Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide within 24 hours a To the Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical (check only one) Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar

0

11595

DHMH 17 Rev 1/2001

Mame and address of person

R 2 0 2012

4940 Eastern Avenue, Baltimore, MD, 21224

who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death I. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Day 2012 Su-Chin Lee Huang March 17, **AKA** Alice S. Huang 8:38 P M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City. Town, or Location of Death 4c. County of Death 13601 Glen Mill Road Rockville Montgomery Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) **Funeral** 8. Date of Birth g. Birthplace (State or Foreign Hours Sept 8, 1950 217-02-2881 **Director** 61 1 □ M 2 🔀 F Taiwan Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City, Town or Location death with the Maryland Director 10d. Inside City Limits notified MD Montgomery Rockville 1 Yes 2X No 10e. Street and Number ö 10f. Zip Code ms 23a or must be 10g. Citizen of What Country? Funeral 13601 Glen Mill Road 20850 USA items 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. ō þ 1 Never Married 2 Married Page 1 and 2 should be filed within 72 hours after ment of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or ury or other traumatic event, the Medical Exami 1 Yes If Yes, Give Baltimore, Maryland 21215-0036 2X No 1 ☐ Yes 2 XNo Specify: Specify: Asian 3 Widowed 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 4 Vice President <u>Acupuncture</u> Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Yen-Chang Lee Chao-Cho Tsai 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Hui Hsiung Huang/husband 3601 Glen Mill Rd. Rockville, MD 20850 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State ☐ Burial 2X Cremation 3 ☐ Removal from State Department o Important: If any injury or Final Journey Crematory 03/20/12 Woodbine, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signatur Funeral Service Licenses 22. Name and Address of Facility Soing Home Cremation Service P.O. Box 784 MO1251Beverly L. Heckrotte, P.A. Clarksville, MD 21029 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Ph_sician/ Onset and Death disease or condition a Lung Cancer with Brain Metastasis vears Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) burial-transit certificate be executed and Due to (or as a consequence of): resulting in death) Last attending physician I for use as the buria Medical P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?

1 Yes 2 No Month Year Pregnant at time of death Day signed by the at d be detached for 9 Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Carcinomatosis Meningitis, Liver Metastasis, Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed Hypertension, Chronic Hepatitis B 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? page 2 s autopsy performed? Yes 2 No 1 Yes 2 No To the Hospital or Attending Physician: funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: 1 ☐ Yes 2X No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 X Residence 6 ☐ Other (Specify) this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of s after death.

1 Director: After the Certificate: 28c. Injury at 28d. Describe how injury occurred 1X Natural 5 Pending injury work? 1 ☐ Yes 2 ☐ No Accident
Suicide Investigation 6 Could not be filled in by the 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number 4 Homicide determined City or Town, State, within 24 hours a

To the Funeral D

completely filled Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Tung P. Lee, M.D. 700 Buckingham Dr. Silver Spring, MD 20901 32. Registrar

State Registrar (Check

only one

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

D26707

29d. Date signed (Month, Day, Year)

March 19, 2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Items State of Maryland / Department of Health and Mental Hygiene Certificate of Death

Rec. No. 1 - State Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Day 14 2012 Mary L. Hartman A^{M} March 2:05 . Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 2017 Ewald Avenue Dundalk Baltimore 5. Social Security Number If Under 1 Year If Under 24 Hrs 7. Age (In vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Funeral (Month, Day, Year) 04/26/1947 Min. Days Country) Maryland 1 □ M 2 F Director 212-48-1258 64 Usual Residence of Decedent 28a-f show 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits with the Maryland notified at **Funeral Director** 1 X Yes 2 □ No MD Baltimore Dundalk 10e. Street and Number ō 10f. Zip Code 10g. Citizen of What Country? must be n 2017 Ewald Avenue 21222 Page 1 and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 2 No Examiner Black, White, etc. ŏ þ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2X No Specify: "natural" Specify. Completed 3 Widowed 4 Divorced White the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working al Hygiene. life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 10 Carrier Healthcare Department of Health and Mental Hyg Important: If item 27 is marked other any injury or other traumatic event, it Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Lewis Earl Paul Rita Weinhold 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Frank Hartman / Husband 2017 Ewald Avenue, Dundalk, MD 21222 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 ☐ Burial 2X Cremation 3 ☐ Removal from State cemetery, crematory or other place) 4 ☐ Donation 5 ☐ Other (Specify) Chesapeake Crematory 3/15/2012 Beltsville, MD Signature of Funeral Service 22. Name and Address of Facility 6 ll Dorota Marshall Maryland Cremation Services, PO Box 1413 Baltimore, MD 21203 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Betweer mall Immediate Cause (Final Onset and Death Ph_sician_ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cauce. Enter Underlying Examine Due to (or as a consequence of) attending physician and for use as the burial-transi Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be ewithin 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physicia P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 month 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy Day Month Year should be detached signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy performed 2 🗆 No 1 Yes filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 2 00 1 🗌 Yes ည 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred injury Natural 5 Pending 1 Yes 2 No Investigation Accident Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Myrse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only d title of ce ate signed (Month, Day, Year)

March 14,2012 29b. Signature 16

Registrar
DHMH 17 Rev 06-2011

State

30. Name

31. Date filed

on who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Sandra J Herman State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Reg. No Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Day March 17, 2012 Sandra Jean Herman **Medical Examiner** 1306 hrs 4a. Facility Name (if not institution, give street and number) 4b, City, Town, or Location of Death 4c. County of Deat N/A Union Memorial Hospital Baltimore 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or **Funeral** 219-44-6186 Months Days Hours Director June 11,1947 Country) 1 M 2 XX Yrs Usual Residence of Decedent 10d. Inside City Limits 10a, State 10b. County 10c. City. Town or Location MDN/A Baltimore 1 XX Yes 2 No Baltimore, MD 21215-0036
permit. Pages I and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho
injury or other traumatic event, the Medical Examiner must be notified at once. Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1128 West 43rd Street 21211 U.S.A. 11. Marital Status 12, Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. 1 Never Married 2 AX Married Yes White 1 Yes 2 No specify: 3 Widowed If Yes, Give Yeer 4 Divorced Specify: ۵ 16a. Decedent's Usual Occupation (Give kind of work done 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired)
Receptionist Elementary/Secondary (0-12) College (1-4 or 5+) Noxzema Company 12th 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) James L. Neal Be Eunice Katherine Althoff 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Tom Herman (Husband) 1128 West 43rd Street Baltimore, MD 21211 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State 1 XX Burial 2 Cremation 3 Removal from State crematory or other place) 3/22/12 Lorraine Park Cemetery Baltimore, MD Donation 5 Other Specify 22. Name and Address of Facility Burgee-Henss-Seitz Funeral Home, Inc. nature of Funeral Service bicensee 3631 Falls Road Baltimore, MD 21211 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval **Physician** failure. List only one cause on each line Between Onset and /Medical Death Complications of Coronary Artery Disease Immediate Cause (Final disease xaminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions if any, leading to immediate cause. Friter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of) Examine Due to (or as a consequence of) events resulting in death) Last and transit Hospital or Attending Physician: The law requires that the death certificate be executed Pahours after death.
Pahours after death. After this certificate has been signed by the attending physician and early filled in by the funeral director, page 2 should be detached for use as the burial - transi sety filled in by the funeral director, page 2 should be detached for use as the burial - transi Physician/Medical X UNPENDED x AMENDED 23a, 23pt.II, 27, 30 per me g925 3-28-12 vt attending physician for use as the burial -Division of Vital Records, P.O. Box 68760, 23d. Date of delivery 23c. If yes, outcome of pregnancy 3b. Was decedent pregnant in the 2 Fetal death Live birth 3 Ectopic pregnancy Month Year past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 V No 9 Unknown 9 Unknown has been signed by the 2 should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ゑ 1 Yes 2 No 3 Probably 4 ✔ Unknown Hypertension, Obesity, Renal Disease Completed 24b. Were autopsy findings available 24a. Was an autopsy prior to completion of cause of ✓ Yes 2 No 1 🗸 Yes 2 No 25. Was case referred to medical 26.Place of Death (Check only one) examiner? Hospital: 1 ✔ Inpatient 2 ER/Outpatient 3 DOA Other Nursing Home 5 Residence 6 Other 1 🗸 Yes 2 No 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 1 X Natural 5 Pending 1 Yes 2 No Accident 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f, Location (Street and Number or Rural Route Number, City 3 Suicide Could not be or Town, State) determined Homicide 29a. Certifier 1 CertifyIng Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Ca 2 📝 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medi and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. March 18, 2012 rd 30. Name and address of person who completed cause of death (Item 23a) Pamela E. Southall, MD Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223 Carol H. Allan, MD 31. Date filed (Month, Day, Year) 32. Registrar's Signature. State

DHMH 17 Rev 1/2001 OCME 2006

Registrar

ORIGINAL

MAR 20

amend 19a, per fh, g925 3-23-12 sm Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month GERTRUDE CATHERINE HOFSTETTER MARCH **2**012 $10:02A^{M}$ Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City. Town, or Location of Death 4c. County of Death BALTO. STELLA MARIS TIMONIUM 5. Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** (Month, Day, Year) MARCH 3,1923 Days Hours Min. Director 1 □ M 2 😾 F 217-14-9974 MARYLAND 89Yrs. Usual Residence of Decedent 28a-f show 10a. State 10b. County notified at 10c. City. Town or Location 10d. Inside City Limits Director MD. BALTO. **ESSEX** 1 Yes 2 No 10e. Street and Number ō 10f. Zip Code 10g, Citizen of What Country? item 27 is marked other than "natural", or items 23a or other traumatic event, the Medical Examiner must be Funeral 1813 OLD EASTERN AVENUE 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates. Black, White, etc þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. WHITE 3 X Widowed 4 ☐ Divorced Specify Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) SALES YARN STORE should be filed with and Mental Hygien is marked other th Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ GEORGE BONHOFF CHRISTINE BILTZ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Important; If item 27 any injury or other tra FREEMAN PASCAL-IV III SON 720 65TH ST. NW MINOT, ND 58703 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) PARKWOOD 3-19-2012 PARKVILLE, MD. 21. Signature of Fineral Service Licensee MILLER-DIPPEL FUNERAL HOME, INC 22. Name and Address of Facility 6415 BELAIR ROAD BALTO.MD. 21206 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) CEREBROVASCULAR ACCIDENT Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events Examine Due to (or as a consequence of): resulting in death) Last Due to (or as a consequence of): Physician/Medical Vital Records, P.O. Box 68760 IE FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) Month Pregnant at time of death Dav Year 1 Yes 2 2 9 Unknown 9 Unknown á Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No Completed 1 Yes 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 certificate has performe Yes 2 X No 1 Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: Other: 2 X No ပ္ 1 Inpatient 2 I ER/Outpatient 3 I DOA this 4 ☐ Nursing Home 5 ☐ Residence 6 **K** Other (Specify) Division of ' 27. Manner of Death 28a. Date of injury 28b. Time of Certificate: 28c. Injury at Hospital or Attending (Month, Day, Year) X Natural 5 Pending injury work? 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director, A completely filled in by the fi M Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated, 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 X Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certif 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) JACKIE JONES, CRNP 2300 DULANEY VALLEY RD. TIMONIUM. Date filed (Month, Day State MAR 2 0 2012 Registrar

10:02

2012

GERTRUDE HOFSTETTER

			For	State of	Maryland		rtment of h		nd Me	ental Hy	giene		
		_	State Registrar			Cer	tificate of L	Death			Reg. No. 2	12	08625
	Physicia	n/	Decedent's Name (First, Middle		. 1 11-	1_				Date of Dea Month		Year	3. Time of Death
	Medic	al		arl Wentz		selli				March		012	7:00am ^M
	Examin	er	4a. Facility Name (if not institution		er)	ļ	4b. City, Town, o				4c. County	4c. County of Death Carrol1	
	Funeral		3815 Boteler 5. Social Security Number		. Age (In yrs. las	st birthday)	If Under 1 Year	t. Air		8. Date of Birt	h l		olace (State or Foreign
	Director		162-14-2599	1 X M 2 □ F	93	Yrs.	Months Days	Hours	Min.	(Month, Day Sept.	8, ^{Year)} 1918	Coun	PA
	D WO		Usual Residence of Decedent 10a. State 10b. County		10- 0:	Town or Loc	-41						0d. Inside City Limits
	ryland I-f sh Ied a	cto	,	Carroll	Toc. City,	, lowil or Loc	Mt. A	irv					1 Ves 2 No
	ne Ma notif	Director	10e. Street and Number	Carrori			10f, Zip Code				10g. Citizen of V	Vhat Coun	
	vith th		3815 Botler R	and			1,	217	71		rog. Onizon or r	**************************************	USA
	tems	Funeral	11. Marital Status	12. Was Deced	ent Ever in U.S.	13. V	/as Decedent of H	ispanic Origin	? (Speci	ify Yes or No-		e - Americ	an Indian,
õ	fter d , or i	by	1 Never Married 2 Ma	If Vac Civo	2 🗌 No		Yes, specify Cuba ☐ Yes 2 🔀 No		Puerto Hi	ican, etc.)		k, White, e Whi	
Š	ours a tural	Completed	3 XWidowed 4 □ Divorced	Year or Dat		11					Specify:		
5	72 hc n "na Aedic	nple	(Specify only high	est grade completed)		(Give k	ent's Usual Occup ind of work done () NOT use retired)		f working	g	16b. Kind of B	usiness/Ind	dustry
21215-0036	within jiene. er tha the f		Elementary/Secondary (0-12)	College (1-4	l or 5+)		tallurgi	st				Stee	1
2	be filed within 72 hours after death with the Maryland ental Hygiene. ked other than "natural", or items 23a or 28a-f sho ic event, the Medical Examiner must be notified at	Be	17. Father's Name (First, Middle,								Maiden Sumame	*)	
yla	Ild be Ment narke	오	Benjamin Wa							Wentz			
Maryland	2 should be filed within 72 hours after death with the Maryland th and Mental Hygiene. 27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at	174	19a. Informant's Name/Relations Mrs. Judith L	hip (Type, Print) (Da	ughter)	19b. Mailin	g Address (Street Boteler						Code)
	and Heal tem (20a. Method of Disposition	yiii Jacobs			sition (Name of	Road,		ate ,	20c. Location -		wn. State
<u>0</u> E	Page 1 nent of ant: If ii ury or c		1 ☐ Burial 2 🔀 Cremation 4 ☐ Donation 5 ☐ Other (1 60	motony orom	atory or other place y Cremat	ion 3				-	e, MD
Baltimore,	permit. Page 1 Department of Important: If i any injury or o		21. Signature of Funeral Service		1	22.	Name and Addre	ss of Facility	HAI	GHT FUN	VERAL HO	ME &	CHAPEL, PA
m			Brian L.	Arught	MOOT	764	PO Box 1	.95 Syk	esv	ille, N	1D 21784		
			23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate course (Final										
jë .	Physician/		Immediate Cause (Final disease or condition resulting in death) .										Onset and Death
-	Medical Examiner		resulting in death)	Due th (c	r as a conseque	ence of):	(633)						112
	100	ner	Sequentially list conditions, if any, leading to immediate	b. Due to (c	r as a conseque	ence of):						_	1 year
	d d ansit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	G								.15	
	executed ian and urial-trans		resulting in death) Last	Due to (c	r as a conseque	ence of):							
9	death certificate be executed to attending physician and ed for use as the burial-transit	edical		d									
189	ertific iding p	/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outc	ome of pregnan	ıcy _					23d Da	te of delive	an/
Box	eath c	iciaı	in the past 12 months?	4 Pregn	ant at time of de		Ectopic pregnand Other (specify)	су				nth	Day Year
		hys	9 Unknown	9 Unkno	wn					1			
0.	The law requires that the death certificate has been signed by the attending page 2 should be detached for use as	Completed by Physician/M	Part II, Other significant conditi	ons contributing to de	ath but not resu	ılting in the uı	nderlying cause gi	ven in Part I.			1/	_	e cause of death?
rds,	een si	sted								1 🗆 '			oably 4 ∐ Unknown
000	has b	mple								24a. Was autor	sy	Vere auto; prior to co death?	osy findings available mpletion of cause of
ž	r: The ficate n; pag	CO	25. Was case referred to medical				00.0	(5 "	<i>(</i> 0: .			I ☐ Yes	2 🗌 No
Ita	sicial s certification	To Be	examiner?	Hospital:	npatient 2 🗆 E	EP/Outpation	Oth	er:	110	14	dence 6 Othe	v (Canaihi	
ot	g Phy er this neral c		27. Manner of Death	28a. Date o		28b. Time of injury	28c. Injur	y at			ow injury occurre		,
on	endin eath. or: Aft the fur	fical		igation	, Day, rear)	Injury	M 1 □	Yes 2 N	0				
Division of Vital Records,	or Attu- fter de irrector in by t	Certificate:	3 Suicide 6 Could 4 Homicide deterr	ninod 28e, Place (of Injury - At hor g, etc. (Specify)	ne, farm, stre	et, factory, office		28	8f. Location (S City or Tow	Street and Numbern, State)	er or Rural	Route Number,
Ξ	pital ours a ceral E		29a, Certifier 1 Certifyin	g Physician: To the be	st of my knowle	edge, death o	ccurred at the tim	e date and pla	ace and	I due to the ca	ause(s) and mann	er as state	ed.
	To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	Medical	(Check 2 Medical		of examination	and/or invest	igation, in my opini-	on, death occu	urred at th	he time, date a	nd place, and due	to the cau	use(s) and manner stated.
	To the within the confidence of the confidence o	_	29b. Signature and title of certifie	r A			29c, Licens	e number			29d. Date signed	(Month, I	Day, Year)
			Kochelle	Ma			KI	1027			3/16	112	
			30. Name and address of person	who completed cause	of death (Item	23a) (Type, P	rint)	N L 1			Accords.	1 /	11771
	Sta	e	31. Date filed (Month, Day, Year)		gistrar's Signat	e Z	109	MOUNT	7	7 1 1	larylan	d O	
	Registr		MAR 20	2012	me p	. 40	-						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 2012 Physician/ March 17, 1:20 РΜ Hilda Josephine Hanford Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Montgomery National Lutheran Home Rockville 5. Social Security Number If Under 8. Date of Birth (Month, Day 7. Age (In yrs. last birthday) 1 Year I If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** Days Hours 1 M 2 X F Months Min. Maryland Yrs. **Director** 577-18-6453 92 1919 Usual Residence of Decedent 28a-f show 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits must be notified at Director 1 X Yes 2 No Rockville Montgomery Maryland 9 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 20850 United States 521 Carr Avenue items within 72 hours after death 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, ori Black, White, etc. þ 1 Never Married 2 Married 1 ☐ Yes 2 🔀 No If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: "natural" Completed 3 X Widowed 4 Divorced Year or Dates White Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done of life. DO NOT use retired) during most of working and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) the 12 Telephone Operator Telephone Company Be filed 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Margaret Josephine Ricketts Richard Henry Gray 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If item 27 is any injury or other tra 521 Carr Avenue, Rockville, Maryland 20850 Catharine H. Clagett/Daughter Page 1 and 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State March 22. Potomac United Methodist Church Cemetery 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 2012 Potomac, Maryland 21. Signature of Funeral Service Licensee Robert A. Pumphrey Funeral Home/Rockville, Inc 300 West Montgomery Avenue, Rockville, Maryland 20850—2805 Som for M01360 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Phylician disease or condition resulting in death) Du to (or as a consequence of): DEMENTIA Medical Examiner ANONEXIA Sequentially list conditions, in the cause. Enter Underlying Examiner Due to or as a consequence of sician and burial-transit Cause (Disease or iiniury that initiated events resulting in death) Last Due to (or as a consequence of): ing physician as the burial Physician/Medical or Attending Physician: The law requires that the death certificate be Records, P.O. Box 68760 IF FEMALE: use 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown for 5 Other (specify) Month Pregnant at time of death Dav Year the Unknown þ Part II. <mark>Other significant conditions</mark> contributing to death but not resulting in the underlying cause given in Part I. signed by be det 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has performed certificate 2 No Yes 2 No 1 🗌 Yes Division of Vital 25. Was case referred to medical funeral director, Be 26. Place of Death (Check only one) examiner? Hospital 2 No Other: 1 🗌 Yes မ 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death nours after death. neral Director: After the filled in by the funeral Certificate: 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 1 Natural 5 Pending 1 🗌 Yes 2 🗌 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Hospital 24 hours Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier within 24 hore To the Fune completed fi 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, gearn occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

State Registrar

DHMH 17 Rev 7/2009

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

Antron

1)0057158

ROCKUILLE

no

VEIN D-

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

701

29d. Date signed (Month, Day, Year)

18

2012

MARCH

no 20850

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ MARCH Mary 4:41 Hammer 2012 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Baltimore Burnie Anne Washington Glen Medical Cente If Under 1 Year If Under 24 Hrs. Social Security Number 7. Age (In yrs. last birthday Birthplace (State or Foreign Country) 6. Sex 8. Date of Birth **Funeral** Months Days Min. 1 - MXX F 9/20/1916 MD Director 212-58-7883 95 Usual Residence of Decedent 28a-f show Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a -f shov any injury or other traumatic event, the Medical Examiner must be notified at 10b. County 10a State 10c. City, Town or Location 10d. Inside City Limits Director MD Glen Burnie 1 Yes 2XXNo Anne Arundel 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code Funeral 904 Dorking Road 21061 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian. 11. Marital Status Black, White, etc. þ 1 Never Married 2 Married 1 Yes 2 No If Yes, Give Year or Dates. HAmmer | Hondaltimore, Maryland 21215-0036 1 ☐ Yes 2XX No Specify: White Specify: XX Widowed 4 Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Own Home Homemaker 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Health and Mental tem 27 is marked o မှ Catherine Bauernshub Ka₁b 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 183 Eastern Road Pasadena, MD 21122 Mr. William C. Hammer / 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State XX Burial 2 ☐ Cremation 3 ☐ Removal from State 3/17/2012 4 ☐ Donation 5 ☐ Other (Specify) Glen Haven Mem Park Glen Burnie, MD 22. Name and Address of Facility Singleton Funeral & Cremation Signatore vice Literatee Services, PA 1 2nd Ave SW Glen Burnie, MD 21061 Part L Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine Due to (or as a consequence of) and burial-trar Due to (or as a consequence of): resulting in death) Last the attending physician the dorns as the burial Physician/Medical the Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE yes, outcome of pregnancy Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 1 Live Birth 2 Fetal dea 4 Pregnant at time of death Ectopic pregnancy in the past 12 months? Month Year 5 Other (specify) 1 Yes 2 No 9 Unknown detached 9 "Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Onknown is certificate has been si director, page 2 should l 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed. this certificate I 2 No 1 Yes 1 Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No ပ္ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA within 24 hours after death. To the Funeral Director: After this completed filled in by the funeral of 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural Pending 1 ☐ Yes 2 ☐ No Accident Investigation Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check only one) Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

Registrar

DHMH 17 Rev 7/2009

State

31. Date filed (Month, Day, Year)

MAR 2 0 2012

MUDION

ss of person who completed cause of death (Item 23a) (Type, Print)

MAREN

CENIR CLER BURNE

12-02196 Tony Hicks

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

2	0	a property	2	0	8	5	2	8
---	---	------------	---	---	---	---	---	---

TOTY THORS	1- For State Certificate of Death Reg. No.
Physician/	1. Decedent's Name (First, Middle,Last) 2. Date of Death Month Day Year Odd44 harm
Medical Examine	Tony Ray Hicks March 17, 2012 U141 hrs 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death
, /	Maryland General Hospital Baltimore
Funeral Director	5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or Foreign Country) TN Usual Residence of Decedent
Au a	10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits
Aaryland 28a-f show 1 at once. ector	MD Baltimore 1 2 No
h the Maryland 3a or 28a-f sh otified at once	
more, MD 21215-0036 Pages I and 2 should be filed within 72 hours after death with the Maryland ront of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at once. To Be Completed by Funeral Director	11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. White Specify:
ours aft attural" amine	or Dates:
5-0036 ed within 72 hour bygiene. other than "natu the Medical Exan	Elementary/Secondary (0-12) College (1-4 or 5+) Costume Director Theater
ID 21215-0036 should be filed within 7 and Mental Hygiene. 7 is marked other than natic event, the Medical TO Be Comple	m
D 2121 should be fil and Mental I is marked atic event,	Raymond Haskell Hicks Linda Faye Booher
ore, MD s I and 2 sho f Health and If item 27 is or traumati	Linda Hicks/Sister 514 Adams Street, Erwin, TN 37650 20a. Method of Disposition Date 20c. Location - City or Town, State 20c. Location -
Baltimore, permit. Pages I at Department of Hee important: If ite	20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other Specify: 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State
Baltimo permit. Page Department of Important:	21. Signature of Funeral Service Licensee Rutter 3 22. Name and Address of Cility Contract of Service Licensee Rutter 8717 Green (ASture SDr. Bullo MD 21286)
Physician /Medical	23a. Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Myocardial Infarction due to Atherosclerotic Approximate Interval Between Onset and Death
Examiner	Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): Due to (or as a consequence of):
	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):
red nsit	cause. Enter Underlying Cause (Disease or injury that initiated
uted nd ransit	Statistissianly in death, Edit
be exection a sician a urial - 1	d. X UNPENDED AMENDED 23a,27 per me g925 3-28-12 vt IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery
iox 68760, eath certificate be executed e attending physician and for use as the burial - transit sician/Medical Ex	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (Specify)
by the attending priced for use as the Physician/	1 Yes 2 No 9 Unknown 9 Unknown 9 Unknown
Division of Vital Records, P.O. tal or Attending Physician: The law requires that the rs after death. al Director: After this certificate has been signed by led in by the funeral director, page 2 should be detach brification: To Be Completed by Pl	1 Yes 2 No 3 Probably 4 V Unknown
Records, The law requirer freate has been sig page 2 should be Completed	24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of
tal Reco	performed? 1 ✓ Yes 2 No 1 ✓ Yes 2 No
Vital Rec ysician: The I his certificate I director, page	25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: A Death of Check only one)
ion of Vi tending Physi eath. tor: After this the funeral dir	27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred
Sion Artendi death. ctor: 2	Natural 5 Pending 2 Accident Investigation
Division o spital or Attending to the death. The filled in by the function: Certification:	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transimal physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transimal Certification: To Be Completed by Physician/Medical E.	29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. One) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)
To with	and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)
	After Broufe Med O.C.M.E. March 17, 2012
Gand.	30. Name en address of person who completed cause of death (Item 23a) Melissa Brassell, MD Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223
State	31. Date filed (Month, Day, Year) 32. Kegistrar's Signatur
Registra	

Cenneth Higgins	F	- For State Registrar		e of Maryla		artment o e <i>rtificate o</i>		nd Ment		Reg. No	201	2 0862
Physician	-	1. Decedent's Name Kennet	e (First, Middle,L h Micha	ast)	gins				2. Date of Do	Day		3. Time of Death 1645 hrs
)		4a. Facility Name (i	f not institution,				4b. City, Town, o	or Location of	March 9		: Ic. County of Dea	
Funeral Director		5. Social Security N 214-58-	0102	Sex 2 F	7. Age (In yrs. 60	last birthday)	If Under 1 Ye Months Da		24Hrs. 8. Date of I		OF4 Fore	Birthplace (State or eign Country) TN
auy		Usual Residence of 10a. State	Decedent 10b. County		I10c Cit	y, Town or Loca	tion					10d, Inside City Limits
E		MD				altimo:						1 Yes 2 No
the Maryland n or 28a-f sh		10e. Street and Nur	mber				10f. Zip Code			10g. Ci	itizen of What Co	ountry?
ith the Maryland 23a or 28a-f abo uotified at once.	5		oston :	St. Apt			2123				SA	
er death wier death	L	11. Marital Status 1 Never Marrie 3 Widowed		12. Was Dece Armed For 1 Yes ed If Yes, Give Year		lf)		an, Mexican,	n? (Specify Yes or I Puerto Rican, etc.)	No-	14. Race - Ame White, etc. Wh: Specify:	
ours at satural satura satural satural satural satural satural satural satural satural	ב ב	15. Decedent's Ed		only highest grade	e completed)		nt's Usual Occup		ind of work done	16b.	Kind of Busines	
215-0036 be filed within 72 hounds Hygiene. rked other than "nat ent, the Medical Exa	Deservice	Elementary/Seco		College (1-	4 or 5+)		r Elect	ricia	an			f Maryland
21215-0036 Muld be filed within 7 Mental Hygiene. marked other than c event, the Medica		17. Father's Name (ggins	,		•		Dolo	Name (First, Middle res Fann	ing	s	
o sh D isi	- 1	^{19a. Informant's Na} Michael							per or Rural Route N			nte, Zip Code) MD 21220
. 6 78 8 6	ı	20a, Method of Disp	position				sition (Name of c		Date	20c	. Location - City	
MOFE Pages 1 tent of Fe tent int: If in	١	1 Burial 2		Removal fro	m State Cl	hesapea	ake Cre		Mar. 18	B		lle, MD
Baltimore, permit. Pages 1 a Department of He Important: If its injury or other tr	- 1	21. Signature of Fu			101585	22.1	Name and Addre	ss of Facility	AFA/Step	hen	D.Loh:	rmann P.A.
Physician	+		e disease, or con		used the deat	18	/1/ Gre	en Pa	astures rdiac or respiratory a	Dr.	Balto	MD 21286 Approximate Interval Between Onset and
y/Medicai Examiner		Immediate Cause (l or condition resultin	Final disease ng in death)	a.Complic: Due to (or as a			hosis o	f the	Liver			Death
		Sequentially list con		b. Due to (or as a	nneen lence	of):						
red nisit		cause. Enter Unde (Disease or injury t	rlying Cause	с		111						
cecuted 1 and - transit		events resulting in	death) Last	Due to (or as a od.	consequence	of):						
10, e be execut ysician and burial - tra		X UNPENDED			3a,27,	per me,	g926 4-1	6-12	sm		-	
Sion of Vital Records, P.O. Box 68760, Attending Physician: The law requires that the death certificate be executed cetor: After this certificate has been signed by the attending physician and by the funeral director, page 2 should be detached for use as the burial - transi-		IF FEMALE: 3b, Was decedent past 12 months		1 Live bir	utcome of pre th int at time of c	2 F6	etal death 3	Ectopic	pregnancy	23	3d. Date of delive Month	ery Day Year
BO)	2	1 Yes 2 N		9 Unknow								
P.O. res that the signed by be detach	5	Part II. Other signif	ficant condition	s contributing to	death but not	resulting in the	underlying cause	given in Par		_		to the cause of death?
of Vital Records, as Physician: The law requires. The the requires the this certificate has been signered director, page 2 should be recorded.	mplere	-						_	per	opsy form <u>ed</u> ?	prior to death?	
Vital Rec ysician: The his certificate director, page		25. Was case refer	red to medical				26.Pla	ce of Death (0	Check only one)	2 [No 1 🗸	Yes 2 No
Physician rathis carthis carth	2 L		2 No		patient 2	ER/Outpatien			Nursing Home 5			er:
n of ding Phy. h. After tl	<u>.</u>	27. Manner of Deat 1 🗶 Natural	h 5 Pending		of Injury Day,Year)	28b. Time of	· · _	ury at Work? Yes 2 1		e how in	ijury occurred	
Division or oppiral or Attending the hours after death. Americal Director: After y filled in by the function.	auman	2 Accident 3 Suicide 4 Homicide	Investig 6 Could n	ation 28e. Place	of Injury - At	home, farm, stre	et, factory, office				and Number or F	Rural Route Number, City
the Ho hin 24 I the Fu upletely		29a. Certifier 1			f examination	-			ce, and due to the ca urred at the time, da			
To wit	Ē	29b. Signature and	title of certifier	Grig Highligh St			1	nse number			Date signed (M	
100		D-7	<u> </u>				0.0	.M.E.		Ma	ırch 11, 2012	?
Sand		30. Name and addre Donna M. V					W. Baltimor	e Street, I	Baltimore, MD 2	21223		
Stat Registra	е	31. Date filed (Mont	n D3/013	32. Reg	gistra s Signa	re Cold						

OCME

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND TTEM#25perPHYS, G925, 3/20/2012, WS
State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day 2012 Physician/ Rudolph Doggett Hertsch 9:30 P. March Medical 4a. Facility Name (if not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death Examiner Sinai of BAITIMAR HOSPI If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Social Security Number 6. Sex 7. Age (In vrs. last birthday) **Funeral** Months Days Hours Min. 217-05-4502 Director 1 🛣 M 2 🗆 F Virginia March 28,1918 93 Usual Residence of Deceden 28a-f show 10d. Inside City Limits 10b. County 10a. State 10c. City. Town or Location Director Examiner must be notified 1 Yes 2 No MD Baltimore Baltimore Known as. Hertsch, Rudolpt, Baltimore, Maryland 21215-0036 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Numbe "natural", or items 23a or Funeral 21244 USA 8107 Windsor Mill Road Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12, Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 Yes 2 No Specify: White ģ 1 Never Married 2 Married 1 Yes 2 No Specify. If Yes, Give Year or Dates Completed 3 ¥ Widowed 4 □ Divorced permit. Page 1 and 2 should be filed within 72 hours Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical E 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b, Kind of Business/Industry Elementary/Secondary (0-12) College (1-4 or 5+) Restaurant Owner/Operator Be 17. Father's Name (First, Middle, Last) 18, Mother's Name (First, Middle, Maiden Surname) Mary Susan Doggett Henry William Hertsch 19a. Informant's Name/Relationship (Type, Print) 9b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8107 Windsor Mill Road; Baltimore, MD 21244 Mary Susan Ittner Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 X Burial 2 Cremation 3 Removal from State 3/16/2012 Woodlawn, MD Woodlawn Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Sterling Ashton Schwab Witzke Funeral Home of Catonsville, Inc. 1630 Edmondson Avenue; Catonsville, MD 21228 21. Signature of Boneral Service In ensee 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final MYOGARDIAL INFARCTION Ph_sician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner DEONARY Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Exami Cause (Disease or injury that initiated events Due to (or as a consequence of): resulting in death) Last attending physician a for use as the burial-Physician/Medical certificate be Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown 5 Other (specify) Pregnant at time of death should be detached the P.O. signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records, Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No 24a, Was an autopsy performe has page 2 I or Attending Physician: after death.

Director: After this certifications funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be exeminer? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 X No 1 Inpatient 2 NER/Outpatient 3 IDOA ၉ 27. Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28a. Date of injury 28d. Describe how injury occurred Certificate: (Month, Day, Year) injury **Matural** 5 Pending Investigation Accident filled in by the 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined To the Hospital o within 24 hours af To the Funeral Di completely filled in Medical **Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29c. License number **PAS#** 6419 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 03/13/20/2 D70396 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DAPPAN BANSAL MA BALTIMORE HEART ASSOCIATES, 8600 LIBERTY ROAD,

Registrar DHMH 17 Rev 06-2011

State

DARPON BANSALM

32. Regist

RANDALLSTOWN, MD 2/133

12-02119 Harris

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

INK UNK		State of Maryland / Department of Health and Mer	ental Hygi	ene	201	2 2062
Dhysisia		1- For State Certificate of Death Registrar 1. Decedent's Name (First, Middle,Last)	12.0	Reg Date of Death	g. No. 201	3. Time of Death
Physiciar Medical Examin	17.6	Timothy Jerome Harris		Month Narch 13, 1		2218 hrs
		4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location			4c. County of Dea	th
Funeral	4		nder 24Hrs. 8.	Date of Birth	h (MM/DD/YYYY) 9. E	irthplace (State or
Director	1	220-76-2688 Months Days Hou	urs Min.		Fore	eign (ountry)
	ŀ	Usual Residence of Decedent		Aug. I	1,1964	MD
w any	ſ	10a. State 10b. County 10c. City, Town or Location				10d. Inside City Limits 1 Yes 2 No
Maryland 28a-f show d at once.	ខ្ញុំ	MD Baltimore 10e. Street and Number 10f. Zip Code		110	g. Citizen of What Co	
or 28s	Director	3988 Roland Ave. 21211		"	USA	unity :
		11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Or			14. Race - Ame	erican Indian, Black,
death or item	Funeral	1 Never Married 2 Married Armed Forces? If Yes, specify Cuban, Mexica	an, Puerto Rica	an, etc.)	White, etc.	lack
s after	<u>ام</u>	3 Widowed 4 Divorced If Yes, Give Year 1 Yes 2 No specific or Dates: 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give		dono	Specify: 16b. Kind of Business	DESCRIPTION OF THE PROPERTY OF
72 hour	Completed	Elementary/Secondary (0-12) College (1-4 or 5+)		CONS	iob, Killa of Basilles	of including
036 ithin 7 ine. r than	흩	10th Laborer			Warehou	se
15-00 filed wit Hygien d other					laiden Surname)	
2121	PB P	James Harris Lo 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Nu	ouise			te. Zip Code)
MD 21215-0036 12 should be filed within 7 12 should be filed within 7 17 is marked other than unante event, the Mediza	-	Nikia Harris (niece) 1704 E.29th St				
	1	20a. Method of Disposition 1 X Burial 2 Cremation 3 Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place)	Da	ate	20c. Location - City of	or Town, State
Baltimore, permit. Pages I as Department of He Important: If ite injury or other to		4 Donation 5 Other Specific Mt. Zion Cemetery	Mar.2	21,20	12 Balto	,Md.
Balt permit. Depart Impor		21. Signature of Foneral Service Licensee 22. Name and Address of Facil Calvin B. So	cruggs	Fune	eral Home	9
Physician	7	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as	SCOII S	ol. Do	arco.Ma.	Approximate Interval
/Medical	ı	failure. List only one cause on each line. Immediate Cause (Final disease a. Gunshot Wounds (2) of Head				Between Onset and Death
FAAIIIIICI	-	or condition resulting in death) Due to (or as a consequence of):				
	ᅵᄚ	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):				
-	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated c. Due to (or as a consequence of):				-
executed an and al - transit	֓֞֞֞֞֞֞֞֞֞֞֞֞֞֞֞֞֞֞֞֞֞֞֞֞֞֞֞֞֞֞֡֓֡	events resulting in death) Last Due to (or as a consequence or): d				
- 5 2 4	dical	UNPENDED AMENDED				
68760 certificate l ading phys	We la	IF FEMALE: 23b. Was decedent pregnant in the 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectop	pic pregnancy		23d. Date of deliver	ry Day Year
Box 6876(death certificate the attending physelefor use as the b	Physician/Me	past 12 months? Pregnant at time of death 5 Other (Specify)	pro programoy		i works	54, 154.
. BO) he death y the att	<u>ڇ</u>	1 Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in F	Part I	23e Did tok	pacco use contribute t	o the cause of death?
that that detz	≦	Takin dalah digimilan dalah da	r dit i.			obably 4 Unknown
ords, P.C. w requires that as been signed to should be deta	Completed			24a. Was a		autopsy findings available
Division of Vital Records, tal or Attending Physician: The law requirers after death. and Director: After this certificate has been sided in by the funeral director, page 2 should be a page 2.	틹			autops perforr 1 Yes 2	ned? death?	
Vital Recysician: The his certificate director, page	ပ္ ရွိ	25. Was case referred to medical 26.Place of Death				
of Viting Physici	ပ	Tes 2 No			Residence 6 Oth	er:
on of Vital sath properties or of Vital or	⊭II	27. Manner of Death 1 Natural 5 Pending 28a. Date of Injury Mar 13, 2012 28b. Time of Injury 28c. Injury at Wo	ISuk	i. Describe hi bject was	ow injury occurred shot	
isio	cat	2 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building,		Location (St	treet and Number or F	Rural Route Number, City
Div	Certification:	3 Suicide 6 Could not be determined (Specify) Local Street	900	or Town, Sta East Port,	ate) , Baltimore, MD	
9 - 2 >	_ ਗੁ	29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death of	place, and due	to the cause	e(s) and manner as sta	ated.
To th within To th	Medical	2 wedical Examiner: On the basis of examination and/or investigation, in my opinion, death of and manner stated. 29b. Signature and title of certifier 29c. License number		s time, date a	29d. Date signed (M	
		On water Andrew Columns O.C.M.E.			March 14, 2012	
	ł	30. N-me and address of person who completed cause of death (Item 23a)				
8	1	Pamela E. Southall, MD Assistant Medical Examiner 900 W. Baltimore Street	et, Baltimor	re, MD 21	223	
Sta Registr		31. Date filed (Month, Day, Year) 32. Registrar's Signature				

DHMH 17 Rev 1/2001 OCME 2006

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ OZ: OF PM 2012 2Truci Medical 4a. Facility Name (if not institution, give street and 4c. County of Death **Examiner** N/A Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** 1 🗆 M 2 💢 F **Director** 65 5-31-1946 MARYLAND Usual Residence of Deceden 28a-f show 10b. County 10d. Inside City Limits 10a. State 10c. City. Town or Location must be notified at Director 1 X Yes 2 ☐ No N/A BALTIMORE MD. 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ō 23a Funeral 225 N. GILMORE ST. 21223 USA Page 1 and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian 11. Marital Status Armed Forces?

1 Yes 2 XNo If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify. BLACK If Yes, Give Year or Dates "natural" 3 Widowed 4 Divorced Completed Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working than, life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) FOOD COOK and Mental Hygie is marked other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ GEORGE HURSEY RETHA BUTLER BLAIR 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 225 N. GILMORE ST. BALTIMORE, MARYLAND 21223 Health a PATRICK AUTREY (SON) 20a. Method of Disposition 1 A Bu/ial 2 A Gren 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State permit. Page 1 a Department of H Important: If ite any injury or ot remation 3
Removal from State Other (Specify) 3-22-2012 4 Donation ZION CEMETERY BALTIMORE, MARYLAND ce Licensee ONATHAN HIBNEL 22. Name and Address of Facility PHILLIPS FUNERAL HOME, P.A. Funeral S D. 1721-27 N. MONROE ST. BALTIMORE, MARYLAND 21217 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arresi Interval Between Onset and Death Immediate Cause (Final disease r condition Physician/ Medical resulting in death) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Cause (Disease or injury that initiated events the Hospital or Attending Physician: The law requires that the death certificate be executed to (or as a consequence of) resulting in death) Last Be Completed by Physician/Medical Box 68760 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

5 Other (specify) IF FEMALE: 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? Month Day Year 1 ☐ Yes 2 g Unknown P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an autopsy perform 25. Was case referred to medical 26. Place of Death (Check only one) examiner?

Yes 2 No Other: Certificate: To 1 Inpatient 2 🗆 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 1 ☐ Yes 2 ☐ No Manner of Death 28b. Time of 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director: After of the funer injury Natural Accider 5 Pending Investigation Accident 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

DHMH 17 Rev 06-2011

State

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 08633 1 - State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ March 18, 2012 5:45P ELINOR PITT **IVES** Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Baltimore Towson Gilchrist 5. Social Security Numbe 6. Sex Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** (Month, Day, Year) Months Hours **Director** 214-22-2263 1 □ M 2**XX**F 84 Yrs 05/29/1927 Maryland Usual Residence of Decedent or 28a-f show 10b. County 10c. City, Town or Location 10d. Inside City Limits at Director Examiner must be notified 1 Tes 2 XXIo Maryland Baltimore Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a by Funeral 21212 USA 802 Kingston Road "natural", or items Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces? Black, White, etc. 1 Never Married XX Married 3altimore, Maryland 21215-0036 1 Yes XX No Specify. If Yes, Give 3 Widowed 4 Divorced White Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) if Health and Mental Hygiene. item 27 is marked other that other traumatic event, the letter traumatic event, the letter traumatic event. Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည William Davis Pitt Zadieth Reese 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 802 Kingston Road Baltimore, Maryland 21212 Paul Pomeroy Ives Husband 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State ō *** Burial 2 Cremation 3 Removal from State Donation 5 Other (Specify) Important: If any injury or once. Druid Ridge Cemetery 03/24/2012 Pikesville, Maryland 22. Name and Address of Facility ignature of Fu ice L Mitchell-Wiedefeld Funeral Home Inc 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, 6500 York Road Baltimore, Maryland 21212 Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ Hoke disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner 10500 ascular Sequentially list conditions, Examine cause. Enter Underlying Cause (Disease or injury burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Day 5 Other (specify) Pregnant at time of death Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably → Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perforn 2 🗌 No 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 No Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) WOSPLY 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 5 Pending 1 Natural 1 Yes Accident Suicide Investigation
6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 \square Homicide determined within 24 hours a

To the Funeral I

completely filled Medical ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier

Division of Vital Records, P.O. Box 68760

State Registrar

6701 N. Charles ST TONOUN M? MAR 20

address of person who completed cause of death (Item 23a) (Type, Print)

(Check

29b. Signature and title of certifier

3 🗌 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month March 2012 Christopher Andrew Joseph 8:00 P M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death 609 Park Avenue Prince George's Laurel 5. Social Security Number If Under 1 Year If Under 24 Hrs. **Funeral** 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Min. Months Days Hours (Month Day, Year) Director 133-44-2907 57 Aug. New York Usual Residence of Decedent or 28a-f shov 10a. State 10b. County with the Maryland 10c. City, Town or Location traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits Director 1XXYes 2 ☐ No Prince George's Laurel 10e. Street and Number 10f Zin Code 10g. Citizen of What Country? Completed by Funeral 23a 609 Park Avenue 20707 USA permit. Page 1 and 2 should be filed within 72 hours after death 1 Department of Health and Mental Hygiene. Innortant: If item 27 is marked other than "natural", or items any injury or other traumatic event, the Medical Examiner muone. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11 Marital Status 14. Race - American Indian, Armed Force Black, White, etc. 1 X Never Married 2 Married Yes 2 X No 3altimore, Maryland 21215-0036 1 🗱 Yes 2 🗆 No Specify: Puerto Rican If Yes, Give Specify: 3 Divorced 4 Divorced White Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life, DO NOT use retired) Department of Elementary/Seconday (0-12) College (1-4 or 5+) 12th Veterans Affairs Program Specialist Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Francis C. Joseph Elsie Bowen 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Kenneth R. Salguero/Partner 609 Park Avenue, Laurel, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) West Arundel Crem. 3/14/2012 Odenton, MD Signati of Funeral Service Licensee 22. Name and Address of Facility Donaldson Funeral Home, M01103 313 Talbott Avenue, Laurel, MD 20707 23a. Part 1 Enter the dis shock of heart failu Immediate Cause (Final ter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Ph_sician Human Immunodeficiency Virus disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate outse. Enter orderlying Cause (Disease or linjury Examiner Due to (or as a consequence of): Hospital or Attending Physician; The law requires that the death certificate be executed the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 inding puse as t IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery atter for u Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death 5 Other (specify) Month Day Year Unknown been signed by the should be detached Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of page 2 s autopsy performed' death? 1 ☐ Yes 2XX No Yes 2 X No 25. Was case referred to medical funeral director, Be 26. Place of Death (Check only one) 1 Yes 2X No Other: မ 1 Inpatient 2 I ER/Outpatient 3 DOA 4 Nursing Home 5 X Residence 6 Other (Specify) 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending 1 Yes 2 No Accident Investigation Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) ò 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Medical 29a. Certifier

24 hours after deat Funeral Director: within 24 ho
To the Fune
completed fi

1 X Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D26287 March 13, 2012

State Registrar 31. Date filed (Month, Day, Year)

egistrar's Signatu

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Michael

Berard

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death Month 03 Physician/ 4:11 Sava Jankovic 2012 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Union Memorial Hospital Baltimore 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday, 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Funeral Hours Director 199-26-5981 88 1 X M 2 □ F May 4, 1923 Serbia 28a-f show 10b. County 10c. City, Town or Location must be notified at 10d. Inside City Limits Director 1 ☐ Yes 2 🔀 No Baltimore Baltimore MD 0 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 8707 Stockwell Road 21234 Serbia "natural", or items be filed within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces? Black, White etc. Completed by 1 Never Married 2X Married 1 Yes Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: white 3 Widowed 4 Divorced Year or Dates ed other than "natur event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working 15 Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Engineer Civil Design marked other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ permit. Page 1 and 2 should be fi Department of Health and Menta Important: If item 27 is marked any injury or other traumatic ev Dmitrije Jankovic Ljubica Stefanovic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sandra Morrison daughter 101 Meadow Creek Drive; Landisville, PA 17538 20b. Place of Disposition (Name of cemetery, crematory or other place)
St. Elijah Serbian 20a. Method of Disposition 20c. Location - City or Town, State Burial Removal from State 5 Other (Specify) 3/17/2012 4 Donatibh Aliquippa, PA 1050 York Road 21. Signature of 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. Towson, MD 21204 23a. Part 1. Enter the disease, or comp shock, or heart failure. List only o ations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph. sician disease or condition Medical resulting in death) (or as a consequence of): **Examiner** Sequentially list conditions riany, reading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to ror as a consequence of or Attending Physician: The law requires that the death certificate be executed Exam and resulting in death) Last Due to (or as a consequence of): physician s the burial Physician/Medical Division of Vital Records, P.O. Box 68760 attending p IF FEMALE nse 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) in the past 12 months? Month Pregnant at time of death Dav Year 1 Yes 2 9 Unknown the 9 Unknown signed by the Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ No 3 Probably 4 Unknown Completed 1 Yes 24b. Were autopsy findings available prior to completion of cause of 24a. Was an this certificate has page 2 autopsy performed? Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 🛮 No Other: 1 🗌 Yes မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify, within 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral is 27 Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Matural Natural 5 Pending 1 Yes 2 Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Hospital Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certified AT 2438946

Registrar DHMH 17 Rev 06-2011

State

201 E. University Pkwy; Baltimore, MD 21218

MY

address of person who completed cause of death (Item 23a) (Type, Print)

andice

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ CLAUDE KANE 03 254 PM Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Samar 000 1timor 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) **Funeral** 24 Hrs Min. **Director** Usual Residence of Decedent 28a-f show Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene.

ant: If item 27 is marked other than "natural", or items 23a or 28a-f shor th and Mental Hygiene. 27 is marked other than "natural", or items 23a or 28a-f shor traumatic event, the Medical Examiner must be notified at 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 No 10g. Citizen of What Country? Funeral Broadu 2/2/3 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 11. Marital Status 14. Race - American Indian. Armed Forces?
1 ☐ Yes 2 No
If Yes, Give Completed by 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 X No Specify. 3 ☐ Widowed 4 ☐ Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during) (Iife. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (4-4 or 5+) Collea Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 19a. Inform nt's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) nisha other Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of Date Department of Important: If it any injury or o 1 Burial 2 Cremation 3 Removal from State 2012 4 ☐ Donation 5 ☐ Other (Specify) Hale thorpe 21. Signature of Fundal Service Licensee 21202 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death SEPTIC .Ph. sician/ SHOCK FAILURE TO THRIVE disease or condition Medical resulting in death) Due to (or as a consequence of Examiner COLITIS, CHRONIC DIARRIED CLOSTRIDIUM Sequentially list conditions, if any, leading to immediate cause. Enter Underlying AIDS Cause (Disease or iinjury that initiated events resulting in death) Last nding physician and ise as the burial-transit Physician/Medical P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day 1 ☐ Yes ∠ ☐ g ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by HYPERBILIRUBINEMIA. CHOLENTHIASIS, Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown HX OF VRE UT 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed after death.

Director: After this certificate 2 No Yes within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical Certificate: To Be Other: 4 \(\text{Nursing Home} \) 5 \(\text{Residence} \) 6 \(\text{Other} \) Other (Specify) 1 Tyes Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work? Accident Suicide 2 🗌 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide City or Town, State) 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifie RES 000 MARCH ompleted cause of death (Item 23a) (Type, Print)

ANA 5601 LOCH RAVEN BLVD, BALTIMORE, MD 21239 PANA LOCH EDMUND RAY 31. Date filed (Month, Day, 32. Registrar's Signature State MAR 2 0 2012

DHMH 17 Rev 7/2009

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 08638 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Day Edward Joseph Kabernagel, Sr. 2012 March 16. 9:30 A Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** 3317 Deer Hill Road Harford County Street 5. Social Security Number If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) 8. Date of Birth **Funeral** (Month, Day, Year) Months Days Hours Min. 1 X M 2 □ F 215-40-5004 69 Director Sept. 1942 Maryland Usual Residence of Decedent 28a-f shov 10b. County 10a, State er than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at 10c. City. Town or Location 10d. Inside City Limits Director Maryland Harford County Street 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 3317 Deer Hill Road 21154 United States 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces? Black, White, etc. ģ 1 Never Married 2X Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2X No Specify: Specify: White Completed 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Machinist/Mechanic American Can Company 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental F Madeline Wojtkowiak Herman Kabernagel permit. Page 1 and 2 should be Department of Health and Men Important; If item 27 is marke any injury or other traumatic. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mrs. Rosemary Kabernagel (Wife) 3317 Deer Hill Road, Street, Maryland 21154 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 🔀 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Evans Funeral Chapel 03/18/2012 Forest Hill, Maryland 22. Name and Address of Facility Evans Funeral Chapel & Cremation Services—Bel Air 13 Newport Drive, Forest Hill, Maryland 21050 21. Signature of Funeral Service Licenses two a 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each, ine. Interval Between Onset and Death Immediate Cause (Final Physician/ cine disease or condition resulting in death) Medical Due to (or as a nsequence of): Examiner Sequentially list conditions, if any, cooling to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examiner Due to for as a consequence of: resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months? Dav Year 9 Unknown 9 I Linknown P.O. has been signed by e 2 should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 1 Yes 2 □ No 3 □ Probably 4 □ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an autopsy performen? Yes 2 is certificate ha director, page 2 Hospital or Attending Physician; The I 24 hours after death. 2 X 1 Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 2 1 မှ 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home Manner of Death 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28a. Date of injury 28b. Time of Certificate: 28d. Describe how injury occurred (Month, Day, Year) Natural 2 Accident 5 Pending injury Investigation 2 Accident
3 Suicide
4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 1 🗶 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of

Registrar

State

31. Date filed (Month, Day, Year,

pleted cause of death (Item 23a) (Type, Print

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month D 3 Day KING 2:20 PM IRVIN 2012 -16 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death GILCHRIST HOSPICE BALTIMORE 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) **Funeral** 8. Date of Birth Birthplace (State or Foreign Country) 220-74-9845 Months Hours **Director** 1 **X**M 2 □ F 05-11-1959 MD show 10c. City, Town or Location **Funeral Director** 10d. Inside City Limits 28a-f BAUTIMORE MD 1X Yes 2 ☐ No 10e. Street and Number or 10g. Citizen of What Country? N. WASHINGTON 21213 2044 USA Page 1 and 2 should be filed within 72 hours after death ment of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or items Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) "natural", or iterr edical Examiner r Race - American Indian, Black, White, etc. Armed Forces' þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify. Completed Specify: BLACK 3 Widowed 4 Divorced Year or Dates marked other than "natu imatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) MEDICAL COUNSELOR Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) A)SBORNE I. KING DORIS MILLER 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) KING MOTHER WASHINGTON ST. DORIS BALTO, MD. 21213 Department of Healt Important: If item 2 any injury or other 20b. Place of Disposition (Name of cemetery, crematory or other place)
KING PARK CEMETRLY 20a. Method of Disposition Date Burial 2 Cremation 3 Removal from State 3/23/2012 BAUTIMORE, MD 4 Donation 5 Other (Specify) 21. Signature of Funeral Septice Licensee 22. Name and Address of Facility VAUGHN GREENE FINERAL SCUS PA MO1353 ROAD. BAND, MO. 21212 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Approximate Interval Between shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician/ Onset and Death HEPATOCOL LULAR CARCINGINA disease or condition MONTHS Medical resulting in death) Due to (or as a consequence of Examiner **EPATITLS** Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should he deteched for the completely filled in by the funeral director, page 2 should he deteched for the completely filled in by the funeral director, page 2 should he deteched for the completely filled in by the funeral director. that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Box 68760 IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? Month Day Year Yes 2 No 9 Unknown g Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by DIABOTES MELLITUS Division of Vital Records, 1 Yes 2 No 3 Probably 4 Onknown PRRIPHERAL VASCULAR DISEASE 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an autopsy performed Yes 2 "HRENIC KIDIVEY DISCASO 1 Yes 2 No 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 2 No 1 Inpatient 2 ER/Outpatient 3 DOA HOSPICE 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one)

State Registrar 29b. Signature and title of certifie

DHMH 17 Rev 06~2011

ed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 20¹2 ELIZABETH 11:55a M LONG KING March Medical 4a. Facility Name (if not institution, give street and number)
Greater Baltimore Medical Cente 4b. City, Town, or Location of Death **TOWSON Examiner** 4c. County of Death Baltimore 5. Social Security Number 6. Sex If Under 24 Hrs. 8. Date of Birth 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Davs Hours Min (Month, Day, Year) 216-20-1536 **Director** 1 □ M 2XX F 89 06/26/1922 Marvland Usual Residence of Deced 28a-f show 10d. Inside City Limits er than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at 10a State 10b. County 10c City Town or Location Director Maryland Baltimore Towson 1 Tes 2 XXVIo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1055 West Joppa Road 21204 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-12. Was Decedent Ever in U.S. 14. Race - American Indian 11. Marital Status Baltimore, Macyland 21215-0036 If Yes, specify Cuban, Mexican, Puerto Rican, etc. Black White etc. by 1 Never Married 2 Married Yes 2 XXVo If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: Specify: ¾☐ Widowed 4 ☐ Divorced Completed White 15. Decedent's Education (Specify only highest grade completed) 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working Hygiene. life, DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 5+ Speech Therapist Public School other t injury or other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) should be file and Mental F is marked o မ Fletcher Horner Long Eleanor Marie Brown 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 s.
Department of Health a
Important: If item 27 is
any injury or Son Stephen M. Doyle 144 West Gilpin Avenue Norfolk, Virginia 23503 20b. Place of Disposition (Name of cemetery, crematory or other place)
GreenMount Crematory 20a. Method of Disposition
1 ☐ Burial 2 XX cremation 3 ☐ Removal from State 20c. Location - City or Town, State Date 03/16/2012 Baltimore, Maryland ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of FacilityMitchell-Wiedefeld Funeral Home Inc 6500 York Road Baltimore Maryland 21212 23a. Part 1. Enter the disease, shock, or heart failure. List ns that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Immediate Cause (Final Onset and Death neumonia Physician/ disease or condition Medical resulting in death) **Examiner** Sequentially list conditions, Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Exami Due to (or as a consequence of): resulting in death) Last physician Physician/Medical certificate be Box 68760 the attending IÉ FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown use 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 ☐ Yes 2 No
9 ☐ Unknown Day Month Year the P.O. signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>Ş</u> Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy performe Yes 2 certificate 2 No 25. Was case referred to medica 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 Inpatient 2 1 Yes မ ER/Outpatient 3 DOA Manner of Death funeral 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred within 24 hours after death. To the Funeral Director: After Hospital or Attending Natural 5 Pending 1 🗌 Yes 2 No ☐ Accident ☐ Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Medical X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check Certifying Nume Practitionen To the best of my thiowisage

DHMH 17 Rev 06-2011

State Registrar npleted cause of death (Item 23a) (Type, Print)

				partment of Health and N	lental Hyg	giene								
			1103.01.01	ertificate of Death		Reg. No. 20 2	08541							
г	Physicia	ın/	1. Decedent's Name (First, Middle, Last)		Date of Dea Month	ath Day Year	3. Time of Death							
· ·	Medic		Kyong Tae Kwon		March	19 2012	5:20 A ^M							
	Examin	er	4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Deatl	1							
-	(* 		Gilchrist Center of Howard County 5. Social Security Number 6. Sex 7. Age (In vrs. last birthda)	Columbia) If Under 1 Year If Under 24 Hrs.	La a de dans	Howard								
	Funeral Director		1460-77-0053	Months Days Hours Min.	8. Date of Birth (Month, Day		hplace (State or Foreign intry)							
	4-1		Usual Residence of Decedent		Jan. 3,	1923 Kor	ea							
	and shov	ğ	10a. State 10b. County 10c. City, Town or	ocation			10d. Inside City Limits							
	Mary 28a-f otifie	Director	MD Howard Columb	.a			1🏋 Yes 2 ☐ No							
	a or 2		10e. Street and Number	10f. Zip Code		10g. Citizen of What Co	untry?							
	s 23	Funeral	6150 Foreland Garth Apt. 205	21045		USA								
	death item	Ē	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?	. Was Decedent of Hispanic Origin? (Spe If Yes, specify Cuban, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Amer Black, White								
36	within 72 hours after death with the Maryland giene. er than "natural", or items 23a or 28a-f sho the Medical Examiner must be notifiled at	d by	1 Never Married 2 X Married 1 Yes 2 X No	1 ☐ Yes 2 🛣 No Specify:			ific Asian							
21215-0036	ours atura	Completed	Tear of Dates.	edent's Usual Occupation										
15	72 h in "na Media	ם	(Specify only highest grade completed) (Giv	edent's Osual Occupation e kind of work done during most of worki DO NOT use retired)	ing	16b. Kind of Business/I	ndustry							
212	within giene. er tha		Elementary/Secondary (0-12) College (1-4 or 5+)	Owner		Constru	ction							
	2 P = 1	Be	17. Father's Name (First, Middle, Last)	18. Mother's Name	e (First, Middle, I									
/lai	d be Menta arked	ပ	Haksoo Kwon	Sunhee	Yoon									
Maryland	1 and 2 should be flie of Health and Mental I item 27 is marked o other traumatic eve		19a. Informant's Name/Relationship (Type, Print) 19b. Ma	iling Address (Street and Number or Rura	al Route Number,	City or Town, State, Zip	Code)							
≥,			Sang T. Kwon/Son 983		Laure	1, MD 2072	3							
Baltimore,	permit. Page 1 and 2 Department of Healt Important: If item 2 any injury or other it once.		20a. Method of Disposition 1 ☐XBurial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Discemetery, co	position (Name of ematory or other place)	Date	20c. Location - City or	Town, State							
Ë	: Pag tmen tant: jury		4 Donation 5 Other (Specify) Crestlay	n Mem. Gard. 3/22		Marriottsv								
Bal	permil Depar Impor any in			22. Name and Address of Facility Don			e, P.A.							
	40100		anul Al ACO MO1103	313 Talbott Avenue										
П			23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Immediate cause (Final disease or condition resulting in death) a. Due to (or as a consequence of):											
Elon,	Physician/ Medical	i i	disease or condition resulting in death)	4 FIBROSIS			MONTHS							
-	Examiner		Due to (or as a consequence of):											
12		Jer	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):											
	rted d ansit	ami	Cause (Disease or injury											
	exect an and rial-tr	EX	that initiated events resulting in death) Last C. — Due to (or as a consequence of):											
09	ate be executed hysician and the burial-transit	dical Examiner	d											
687	tifical ng ph as tl		IF FEMALE:											
9 ×	th cer tendi	ian/	23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 3			23d. Date of deli	•							
Вох	dear the at hed for	Physician/Me	1 Yes 2 No 4 Pregnant at time of death 5 9 Unknown	Other (specify)		Month	Day Year							
P.O.	rat the		Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.	23e. Did tol	bacco use contribute to	the cause of death?							
S, F	signe d be	d by				res 2 □ No 3 □ Pro								
ğ	requi been shoul	lete			24a. Was a		opsy findings available							
ecc	e law e has ige 2	Completed			autops	sy prior to c med? death?	ompletion of cause of							
<u>د</u>	in; Th ificate or, pa		25. Was case referred to medical	26. Place of Death (Check	1 Yes	2 No 1 Yes	2 No _							
Vita	ysicia s cert direct	To Be	examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 EP/Outpat	0.11		ence 6 X Other (Specif	HOERICE							
Division of Vital Records,	g Physer this		27. Manner of Death 28a. Date of injury 28b. Time	of 28c. Injury at		ow injury occurred	<i>y</i>)							
on	endin sath. ir; Aft he ful	fica	2 Accident Investigation	work? M 1 ☐ Yes 2 ☐ No										
/isi	r Atte	Certificate:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined building, etc. (Specify)	treet, factory, office	28f. Location (St City or Town	reet and Number or Rura	al Route Number,							
<u>Ö</u>	ital o urs af ral Di			ļ										
	To the Hospital or Attending Physician; The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Medical	29a. Certifier (Check (Check 2 Medical Examiner: On the best of my knowledge, deat	stigation, in my opinion, death occurred at	the time, date an	d place, and due to the ca	ause(s) and manner stated.							
	o the	Σ	only one) 3 Certifying Nurse Practitioner: To the best of my knowledge 29b. Signature and title of certifier	e, death occurred at the time, date and pla 29c. License number		e cause(s) and manner as 29d. Date signed (Month,								
	F S F O					MARCH	9,2012							
	'		30. Name and address of person who completed cause of death (Item 23a) (Type	Print)		· · · · · · ·	-/-							
)			DANIEUE DOBERMAN, MD 6:	336 CEDAR LAN	E COL	umbit, ML	21044							
	Stat	е	31. Date filed (Mooth, Day, Year) 2012 Registrar's Signature		-									
	Registra	ir	MAIL W U 2012 Change of the	and I										

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death ^{Day}2012 Physician/ March 15, 1:59 PM James Charlton Kelly Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Suburban Hospital Montgomery Bethesda 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) **Funeral** Months Days Hours Min (Month, Day, Year) **Director** 579-50-2501 1 🛛 M 2 □ F 73 September 22, 1938 Washington, D.C. Usual Residence of Decedent 28a-f show aţ 10c. City, Town or Location 10d. Inside City Limits Director Examiner must be notified 1 Yes 2 X No Maryland Montgomery Silver Spring 10e. Street and Number 10f. Zip Code items 23a or 10g. Citizen of What Country? Funeral 10000 Brunswick Avenue # 103 20910 United States 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 🐧 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. marked other than "natural", or 1 X Never Married 2 Married þ 3altimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. Specify: Completed 3 Divorced 4 Divorced White Year or Dates traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) Apartment Houses Desk Clerk Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Mary Arlene Jenkins Francis J. Kelly 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Louis G. Kelly / Brother 8208 Windsor View Terrace, Potomac, MD 20854 mportant; If item 27 injury or other 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State March 19, . Page 1 cemetery, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State Fort Lincoln Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 2012 Brentwood, Maryland 21. Signature of Funds Service ensec Robert A. Pumphrey Funeral Home, Bethesda-Chevy Chase, Inc. M01619 7557 Wisconsin Avenue, Bethesda, Maryland 20814 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Onset and Death Immediate Cause (Final Ph sician/ SEPSUS disease or condition Medical resulting in death) Examiner PNEUMONIA Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Box 68760 amcs as IF FEMALE use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 months? Month Day Year Pregnant at time of death 2 No 9 Unknown 9 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 7 No 3 ☐ Probably 4 ☐ Unknown page 2 should 24b. Were autopsy findings available 24a. Was an autopsy prior to completion of cause of death? 1 Tes 2 Po ☐ Yes 25. Was case referred to medical examiner? Hospital or Attending Physician: Be 26. Place of Death (Check only one) Hospital Other: 2 No ပ 1 Yes 1 P Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at work? 28d. Describe how injury occurred injury 1 Natural 5 Pending 1 Yes 2 No Accident Investigation the Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, filled in by 4 Homicide determined 24 hours a Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 00057124 ano, mg 7116112 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Truong Bao, M.D. 10110 Molecular Drive #206, Rockville, Maryland 20850 State Registrar DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Certificate of Death Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death March 17 ay 2012^{ear} Physician/ 11:30 AM David Krausz Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore Towson Gilchrist If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** Days (Month, Day, Year) Hours 1 🛚 M 2 □ F Director 217-64-7075 57 Feb. 17,1955 Maryland Usual Residence of Decedent or 28a-f show notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State Director 1 Yes 2X No Columbia Maryland Howard 10f. Zip Code 10g. Citizen of What Country? 10e, Street and Number ō er than "natural", or items 23a or the Medical Examiner must be with Funeral U.S.A. 21044 10081 Windstream Drive, within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?
1 ☐ Yes 2 X No by 1 Never Married 2 Married ☐ Yes Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🕅 No Specify: If Yes, Give Specify: 3 Widowed 4 X Divorced White Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry th and Mental Hygiene.
27 is marked other than '
traumatic event, the Me Elementary/Secondary (0-12) College (1-4 or 5+) Business Manager Automotive Industry Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last, ၉ permit, Page 1 and 2 should be Department of Health and Ment Important: If item 27 is marke any injury or other traumatic once. Louis Krausz Christine Wuestner Harry 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 28280 Hemmersley Street Easton, Maryland <u>Brother</u> <u>Timothy Krausz</u> 20b. Place of Disposition (Name of Durattey review Pretter place) Memorial Gardens 20a. Method of Disposition 20c. Location - City or Town, State Date 1X Burial 2 Cremation 3 Removal from State 3-23-2012 Timonium Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. Signature of Funeral Service Lice Towson. Marvland 1050 York Road 23a. Part 1. Enter the disease, or complication that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Se uentiall, list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine Due to (or as a consequence of) and I-transit Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events Due to (or as a consequence of): resulting in death) Last physician a Physician/Medical Division of Vital Records, P.O. Box 68760 as. the attending IF FEMALE: Se 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ ò in the past 12 months?
1 ☐ Yes 2 ☐ No Day Month Year Pregnant at time of death 9 Unknown Unknown s been signed by to 2 should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of has page 2 autopsy death? certificate 1 Yes 2 No Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital Other: 2 🗆 No 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence မြ this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c, Injury at 28d. Describe how injury occurred Certificate: within 24 hours after death.

To the Funeral Director: After completely filled in by the funer injury 1 Natural 5 Pending 1 Yes 2 No 2 Accident Investigation Suicide 6 Could not be 3 ☐ Suicide 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 29a. Certifier 1 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

State Registrar

only one)

29b. Signature a

DHMH 17 Rev 06-2011

m(

of person who completed cause of death (Item 234) (Type, Print)

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

29d. Date signed (Nonth, Day, Year)

MAVA 17, 2812

6701 N- Charles St. Balts and

Emma Klein	State of Maryland / [1-For State Registrar	Department of Health an Certificate of Death		g. No. 2012 0864						
Physician/ Medical Examiner	1. Decedent's Name (First, Middle,Last) Emma Helen Klein		2. Date of Death Month March 14,							
	4a. Facility Name (if not institution, give street and number) St. Agnes Hospital	4b. City, Town, o Baltimore	or Location of Death	4c. County of Death						
Funeral Director	219-10-2118 1_M 2\sqrt{F}	In yrs. last birthday) 86 Yrs. If Under 1 Ye Months Da		h (MM/DD/YYYY) 9. Birthplace (State or Foreign Country) MD						
Maryland 28s-f show any d at once.	Usual Residence of Decedent	Oc. City, Town or Location Catonsville		10d. Inside City Limits 1 Yes 2 No						
th the Maryland 23a or 28a-f sh 20tified at one	10e. Street end Number 1938 Altavue Road	10f. Zip Code 21228	US	g. Citizen of What Country?						
Baltimore, MD 21215-0036 permit. Pages I and 3 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 37 is marked other than "matural", or items 33a or 28a-fabo injury or other traumatic event, the Medical Examiner must be notified at once. To Be Completed by Funeral Director	11. Marital Status 1 Never Married 2 Married Armed Forces? 1 Yes 2 Married 1 Yes, Give Year or Dates:	If Yes, specify Cuba	ispanic Origin? (Specify Yes or No- an, Mexican, Puerto Rican, etc.) o specify:	White, etc. Specify: White						
5-0036 ed within 72 hour tygiene. other than "natu the Medical Exan Completed	15. Decedent's Education (Specify only highest grade completed in the Elementary/Secondary (0-12) College (1-4 or 5+)	during most of working life	e. DO NOT use retired)	16b. Kind of Business/Industry Own Home						
21215-0036 bould be filed within 7 d Mental Hygiene. is marked other than tic event, the Medica To Be Comple	17. Father's Name (First, Middle, Last) Jacob Carl Vitak 19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Stre	18.Mother's Name (First, Middle, M Betty Bernat set and Number or Rural Route Numb							
nore, MD 2 ages 1 and 2 shoul nt of Health and Int: If item 27 is no other traumatic	Lillian Vitak Bloom Siste 20a. Method of Disposition	r 1606 Loch Ne	ss Road; Towson,							
Baltimore, permit. Pages I and Department of Heal Department of Heal Important: If iten injury or other tra	1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other Specify: 21. Signature of Euroral Service Licenses	Meadowridge Mem.	ss of Facility terling As	Elkridge, MD hton Schwab Witzke						
Physician	23a. Part I. Enter the disease, or complications that caused the failure. List only one cause on each line.	Funeral Ho 1630 Edmon e death. Do not enter the mode of dying	me of Catonsvilledson Avenue; Cato g, such as cardiac or respiratory arre-	e, Inc. Dnsville, MD 21228 st, shock, or heart Approximate Interval Between Onset and						
/Medical Examiner	Immediate Cause (Final disease or condition resulting in death) a. Complications of L Due to (or as a consequence) b.	<u> </u>		Death						
ted Insit Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):									
be execuician and unial - tra	d. UNPENDED AMENDED									
Division of Vital Records, P.O. Box 68760 to the Hospital or Attending Physician: The law requires that the death certificate the within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physicompletely filled in by the funeral director, page 2 should be detached for use as the buedical Certification: To Be Completed by Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 ✓ No 9 Unknown 23c. If yes, outcome of 1 Live birth 4 Pregnant at tim 9 Unknown	2 Fetal death 3	Ectopic pregnancy	23d. Date of delivery Month Day Year						
ords, P.O. I v requires that the been signed by the should be detached better by the should be detached by Pr.	Part II. Other significant conditions contributing to death be Osteoporosis, Hypertensive Atherosclerotic	_	•	pacco use contribute to the cause of death? 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available						
Division of Vital Records, talor Attending Physician: The law requires as after death. In Director: After this certificate has been signed in by the funeral director, page 2 should be artification: To Be Completed	25. Was case referred to medical	26 Plea	autops: perform 1 V Yes 2 e of Death (Check only one)	y prior to completion of cause of ned? death?						
f Vital F Physician: er this certificated in To Be C	examiner? 1 Yes 2 No Hospital: 1 Inpatient		Other —	Residence 6 Other:						
ision of Attending Physic death. rector: After the by the funeral	27. Manner of Death 1 Natural 5 Pending 2 Accident Investigation	1115 hrs 1	Yes 2 ✓ No Subject push	ow injury occurred ed down striking fireplace mantel						
Division o Biopital or Attending 24 hours after death. Funeral Director: After stelled in by the funeral Control of the funeral Control of the funeral Control on the funeral Control o	4 V Homicide determined (Specify) Town	y - At home, farm, street, factory, office house / Rowhouse	or Town, Sta 1938 Altavue A	venue, Catonsville, Md.						
To the Hos within 24 h To the Fur completely	(Check only one) 2 Medical Examiner: On the basis of examinand manner stated.	ation and/or investigation, in my opinio	n, death occurred at the time, date a	nd place, and due to the cause(s)						
	29b. Signature and title of certifier		Table 1	29d. Date signed (Month, Day, Year) March 16, 2012						
0		Examiner 900 W. Baltimore	Street, Baltimore, MD 212	223						
State Registrar	31. Date filed (Month, Day, Year) NAR 2 0 2012	Signature Sark								
DHMH 17 Rev 1/2001	OCME	ORIGINAL								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 9:00A 1 4 Day Physician/ 0^{Month} 20 1ª2 Marvin Kenneth King Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore N/A Joseph Ritchie If Under 1 Year If Under 24 Hrs. 5. Social Security Number 214-56-4663 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Hours Min (Month, Day, Year) Director 1**x** M 2 □ F Yrs 08/22/1951 New York 60 fshow 10b. County be filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits item 27 is marked other than "natural", or items 23a or 28a-f sho other traumatic event, the Medical Examiner must be notified at Director 1 Yes 2 No N/A Baltimore MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Completed by Funeral 21215 U.S.A. 3047 Borman Ave. 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-11 Marital Status 14. Race - American Indian. Armed Forces If Yes, specify Cuban, Mexican, Puerto Rican, etc. Black, White, etc. 1 Never Married 2 Married Yes Yes 2 X No Maryland 21215-0036 1 Yes 2 Klo Specify: If Yes, Give Specify: Black 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) and Mental Hygiene. is marked other than Elementary/Secondary (0-12) College (1-4 or 5+) Camera Man CBS News years Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Joseph King Jr. Delphine Edwards 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) and 2 s Health a 2501 Violet Ave. #604N, Balto., MD 21215 Sharon King(sister) Department of Healt Important: If item 2 any injury or other 3. Itimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1
Burial 2
Cremation 3
Removal from State on-site Crematory03/18/12 Baltimore, MD 4 ☐ Donation 5 ☐ Other (Specify) ature of Funeral Service Licensee 3035ephd H. Brown Jr. 2140 N. Fulton Ave., Funeral Home PA Baltimore, MD21217 23a. Part 1. Enter he disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or beart failure. List only one cause on the line. iterval Between et and Death Immediate Cause (Final Ph_sician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, Physician/Medical Examiner Due to for as a consequence of cause. Enter Underlying Cause (Disease or injury that initiated events nding physician and use as the burial-transit death certificate be executed Due to (or as a consequence of): resulting in death) Last the attending physician IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy
4 Pregnant at time of death 5 Other (specify) 23b. Was decedent pregnant 23d. Date of delivery been signed by the atte should be detached for in the past 12 months? Day Yes 2 □ No 1 Yes 2 9 Unknown 9 Unknown Part II. Other significant conclions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death Completed by To the Hospital or Attending Physician: The law requires I within 24 hours after death.

To the Funeral Director: After this certificate has been sign completely filled in by the funeral director, page 2 should be 1 Yes 2 No 3 Probably 42 nknown Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performe death? 2 No ☐ Yes Be (25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital Other: 2 1 No ပ 1 Yeş 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence Certificate: of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Natural 5 Pending injury 1 Yes 2 No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Conflicting Nurse Practitioner: To the boat of my new logs Seath occurred at the time, date and place and place and place and other to the cause at stated. obtribled at the time, date and place, and due to the cause(s) and manner as state 29b. Signature and title of certification ause of death (Item 23a) (To State Registrar DHMH 17 Rev 06-2011

			State of Maryland / Dep			ental Hygi	ene	2 08646
		_ 1	State C6	ertificate of Dea	ath			
	Dhysisis	2/	1. Decedent's Name (First, Middle, Last)			2. Date of Death Month	16, 2012 Yes	3. Time of Death 6:39 PM
	Physicia Medic	al		perger		March		
2	Examin	_	4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Loca			4c. County of D	
- marke of the			Maryland Masonic Homes	Cockeysv		8. Date of Birth		imore Birthplace (State or Foreign
	Funeral		5. Social Security Number 218-10-1541 6. Sex 1 M 2 X F 7. Age (In yrs. last birthday yrs. 1		ours Min.	July 25		Country) Maryland
	Director		Usual Residence of Decedent			041) 23	,	
	show	5	10a. State 10b. County 10c. City, Town or	ocation				10d. Inside City Limits
	faryla 8a-f tified	Director	MD Baltimore Cock	eysville				1 🗆 Yes 2 ื No
	or 2		10e. Street and Number	10f. Zip Code		10	0g. Citizen of What	: Country?
	with s 23a ust b	Funeral	300 International Cir.	21030			US	
	leath items er m	F	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?	 Was Decedent of Hispar If Yes, specify Cuban, M 	nic Origin? (Spec lexican, Puerto F	cify Yes or No- Rican, etc.)		merican Indian, /hite, etc.
98	fter of ', or amin	ğ	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 🚻 No	1 ☐ Yes 2 🌠 No Sp	pecify:		Specify:	White
Ö	urs a tural	ted	3 🕅 Widowed 4 🗆 Divorced Year or Dates.	cedent's Usual Occupation			16b. Kind of Busin	ess Industry
21215-0036	72 hc n "na ledic	Completed	(Specify only highest grade completed) (Gi	re kind of work done during DO NOT use retired)	g most of workir		TOD: Talla of Eduli.	
12	ithin ene. r thai	ပြင်	Elementary/Seconday (0-12) College (1-4 or 5+) N/A	Bookkeeper			Accou	inting
d 2	Hygi othe	B	17. Father's Name (First, Middle, Last)	18.		(First, Middle, M		
lan	l be f fenta rked ric ev	은	Albert Raiber		Rebec	Joliffe	<u> </u>	
Maryland	thould and N is ma		1	ailing Address (Street and I				
Σ	nd 2 salth n 27 er tra			A Mt Wilso			nore, MD	
ore	of He	1000	1 N Rurial 2 Cremation 3 Removal from State cemetery, c	sposition (Name of rematory or other place)	March	720,	20c. Location - Cit	1
Ĕ	Page ment tant: lury o		4 Donation 5 Other (Specify)	dge Cemetery			Baltimor	
Baltimore,	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, the Medical Examiner must be notified at once.		21. Signature of Funeral derivice Livensee	22. Name and Address of Lemmon Funer 10 W. Padon	f Facility al Home	of Dula	ney Vall	ey, Inc.
	<u> </u>	_	Mightel J. Flagle 23a. Part Enter the disease, lications that caused the death. Do not death.					Approximate
			shock, or heart failure. List only one cause on each line.	4				Interval Between Onset and Death
	Physician/ Medical		Immediate Cause (Final disease or condition resulting in death) a. Due to (or as a consequence of):	eur.				
-	Examiner		Due to (or as a consequence or).					
	NIV.	ē	Sequentially list conditions, if any, leading to immediate b. Due to (or as a consequence of):					
	ted Insit	Ē	Cause (Disease or linjury					
	executing and ial-tra	Ä	that initiated events resulting in death) Last C. Due to (or as a consequence of):					
09	sician: The law requires that the death certificate be executed certificate has been signed by the attending physician and rector, page 2 should be detached for use as the burial-transit	dical Examiner	d					
6876	tificat ng ph as th	ĕ	IF FEMALE:					
9 ×	h certendii	ian/	23b. Was decedent pregnant in the past 12 months?	3 Ectopic pregnancy			23d. Date of Month	
Box	deat the at ned fo	/sic	In the past 12 morens? 1 □ Yes 2 □ No 9 □ Unknown 4 □ Pregnant at time of death 9 □ Unknown	5 Other (specify)				
P.O.	at the d by t letach	문	Part II. Other significant conditions contributing to death but not resulting in the	ne underlying cause given	in Part I.	23e. Did tol	pacco use contribu	ite to the cause of death?
	res th signe	Completed by Physician/Me	Hyps Colettes, 4 h	Herpoth	nelsi	1 □ Y	es 2 🗆 No 3	Probably 4 Unknown
ğ	requir	ete	and have talke to be	.0.		24a. Was a		re autopsy findings available or to completion of cause of
၁၁	has law	E	med finetter,			autops perfor	med? dea	th? Yes 2 No
Ä	n: The ficate or, pag	ပြင္တို	25. Was case referred to medical	26. Place	e of Death (Checi		21111101 12	103 2 2 10
/ita	sicial certi	To Be	examiner? Hospital:	atient 3 DOA Other:	4 Wursing Ho	me 5 🗆 Reside	ence 6 Other (Specify)
of.	Phy eral d	ë		e of 28c. Injury at	t	28d. Describe ho	w injury occurred	-
n (nding ath. r; Afte ie fun	icat	1 Natural 5 Pending (Wonth, Day, Year)	M 1 ☐ Yes	s 2 🗆 No			
Division of Vital Records,	Atte er de recto by th	Certificate:	3 ☐ Sulcide 6 ☐ Could not be 4 ☐ Homicide determined 28e. Place of Injury - At home, farm building, etc. (Specify)	street, factory, office		28f. Location (St City or Town	treet and Number on, State)	or Rural Route Number,
<u>S</u>	ital ol Irs aft ral Di	3 C			-4	ad due to the call	sea(s) and manner:	as stated
	Hospital or Attending Physician: 24 hours after death. Funeral Director: After this certific	Medical	29a. Certifier (Check (Check only one) 3 Certifying Physician: To the best of my knowledge, de control of the best of my know	vectigation in my oninion	death occurred a	t the time, date ar	nd blace, and due () (The Cause(s) and mainten stated.
	the hin the	ž	only one) 3 Certifying Nurse Practioner. To the best of my knowled 29b. Signature and title of certifier.	ge, death occurred at the tir 29c. License nu			29d. Date signed (
	라		RT Cloubs	Do	1410		3/19/16	2
	7		30. Name and address of person who completed cause of death (Item 23a) (Ty)	pe, Print)	10/		1-11	
Q				in 5+ Bee	lto no	615 m	2x	
	Sta	ate	31. Date filed (Month, Day, Year) 32. Aegistrar's Signature	hall	/		/	

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Day 2012 March 18, Physician/ 3:40 A M Mary Elizabeth Lewis Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Montgomery Montgomery Hospice Casey House Rockville If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) Social Security Number 7. Age (In yrs. last birthday 8. Date of Birth **Funeral** Min (Month, Day, Year) 264-34-5035 Director 1 🗆 M 2 🗓 F 85 Jan. 10, 1927 Florida Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location the Maryland Director or 28a-f sl 1 Yes 2 No Montgomery Maryland Rockville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ō must be 23a Funeral death with 10706 Kings Riding Way #102 20852 United States iral", or items a Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian. Armed Forces?

1 Yes 2 No Black, White, etc. or i . Page 1 and 2 should be filed within 72 hours after trent of Health and Mental Hygiene.
tant: If item 27 is marked other than "natural", or lury or other traumatic event, the Medical Examirury or Completed by 1 Never Married 2 Married Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛛 No Specify: White Specify: 3 Widowed 4 X Divorced Year or Dates 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Walter Edwards Mary D. Wilson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mary Diane Mouser/Daughter Laura Lane, Saratoga, New York 12866 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date Department of H Important: If ite any injury or oth March 20, 1 Burial 2 X Cremation 3 Removal from State Bethesda, Maryland Montgomery Crematorium 2012 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licenses M01173 Robert A. Pumphrey Funeral Home, Bethesda-Chevy Chase, Inc. 7557 Wisconsin Avenue, Bethesda, Maryland 20814 Millia a. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death shock, or heart failure. List only one Immediate Cause (Final Ph. sician/ Pancreatic Cancer disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): Cause (Disease or Injury that initiated events resulting in death) Last Hospital or Attending Physician: The law requires that the death certificate be executed burial-tra Due to (or as a consequence of) physician Physician/Medical Division of Vital Records, P.O. Box 68760 the as attending p IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery ☐ Live Birth 2 ☐ Fetal deal ☐ Pregnant at time of death 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 Yes 2 No Month Day Year hed 1 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by be 1 Tes 2 No 3 Probably 4 X Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s Jas autopsy performe 2 No certificate Yes 2 X No 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 1 ☐ Yes 2 🗓 No မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 🕅 Other (Specify) Hospice After this funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 X Natural 5 Pending injury work s after death. 1 Yes 2 No Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 24 hou

To the Fune

completely fi (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one

State Registrar Debrah Miller, CRNP 1355 Piccard Drive, Suite 100, Rockville, MD MAR 2

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

and title

DHMH 17 Rev 06-2011

29c. License number

R143201

29d, Date signed (Month, Day, Year,

20850

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

amend #5 Per FH G925 3/27/2012 JH
State of Manyland / Department of Health and Mental Hygiene

		•	For State Registrar	State of Maryland		tificate of L			Reg. No. 🤈 🎧	112	08618
ì	Physicia	n/	1. Decedent's Name (First, Middle, Last)					2. Date of Dea Month	Day 15	Year	3. Time of Death
12.	Medic Examin	al	Delia McKee 4a. Facility Name (if not institution, give s	treet and number)		4b. City, Town, or	Location of Death		4c. County		W
magain 19 ²⁵	<u>′ </u>		University of Marganel Who		- 4 de de-4de - de - 3	3 Himere	If Under 24 Hrs.	☐ 8. Date of Birt	N/		Law (Date of Free Law)
	Funeral Director		5. 9cp rd Security Number 215-32-3319 Usual Residence of Decedent	7. Age (In yrs. Ia	st birthday) Yrs.	Months Days	Hours Min.	Month, Day Sept 25	, Year)	Cour	place (State or Foreign htry) yland
	Maryland 18a-f shov Aified at	Director	Maryland 10b. County Anne Aru		, Town or Loc sadena	cation					10d. Inside City Limits X 1 Yes 2 No
	with the l s 23a or 2 lust be no	Funeral Di	10e. Street and Number 229 12th Street			10f. Zip Code	21122		10g. Citizen of U	What Coul	ntry?
900	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	ğ	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☐ XWidowed 4 ☐ Divorced	12. Was Decedent Ever in U.S Armed Forces? 1 ☐ Yes 2 X No If Yes, Give Year or Dates.	- 1	Vas Decedent of H Yes, specify Cuba		ecify Yes or No- o Rican, etc.)		ck, White,	ean Indian, etc. ite
Maryland 21215-0036	thin 72 hou ane. than "n at t e Medica	Completed	15. Decedent's Edu (Specify only highest grad Elementary/Secondary (0-12)		(Give k life. DC	lent's Usual Occup gind of work done of DNOT use retired) Derator		king	16b. Kind of B		• 911
nd 2	filed wi	Be	17. Father's Name (First, Middle, Last)		-		18. Mother's Nan			e)	
Ŋaı	uld be I Menta narked natic e	မ	Daniel	0.11	Santo		Alm				hambault
, Ma	and 2 sho Health and tem 27 is I		19a. Informant's Name/Relationship (Type Frank A Stokes II)	I son	821	g Address (Street a	Diamond	ct. Pasa	adena MD	211	22
Baltimore,	Page 1 ament of Hament: If itel		20a. Method of Disposition 1 Burial 2 Cremation 3 4 Other (Specify)	Removal from State Met	emetery, crem	sition (Name of natory or other place ematory I	inc 3/17		20c. Location Baltimo	re M	D
Balt	permit. Depart Import any inj		21. Sign Ture V Funeral Service Licente	29	22	Name and Addres	ss of Facility ountain R	Stalling oad Pasa			
۲	Physician/		23a. Part 1. Enter the disease, or comp shock, or heart failure. List only of Immediate Cause (Final	ications hat caused the death e cause on each line.	. Do not ente	r the mode of dyin	g, such as cardiac	or respiratory arr	est,		Approximate Interval Between Onset and Death
	Medical Examiner		disease or condition resulting in death)	Due to (or as a consequent		ent					10 days
	Examiner	ier	Sequentially list conditions,	Due to lor as a conseque	+	2					unknown_
	uted nd ransit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	o							
0	icate be executed g physician and as the burial-transit	edical E	resulting in death) Last	Due to (or as a consequent	ence of):						
8760	ifficate ng phy as the		IF FEMALE:								
. Box 68	To the Hospital or Attending Physician: The law requires that the death certific within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use as	Physician/N	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	3c. If yes, outcome of pregnar 1 ☐ Live Birth 2 ☐ Fetal 4 ☐ Pregnant at time of d 9 ☐ Unknown	death 3	Ectopic pregnand Other (specify)	ey			ite of deliventh	very Day Year
ls, P.O.	uires that th n signed by uld be deta	þ	Part II. Other significant conditions con	ntributing to death but not resu	ulting in the u	nderlying cause giv	ven in Part I.				he cause of death?
Division of Vital Records,	The law require ate has been si page 2 should	Completed						24a. Was a autop perfor 1 Yes	rmed?	Were auto prior to co death? 1 \sum Yes	opsy findings available ompletion of cause of
tal	ician: Sertifica rector,	Be	25. Was case referred to medical examiner?	ospital:		26. Pl	ace of Death (Chec				
n of V	ding Phys h. After this funeral di	sate: To	1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending	1 ☑ Inpatient 2 ☐ 28a. Date of injury (Month, Day, Year)	ER/Outpatien 28b. Time of injury	t 3 L DOA 28c. Injun	4 ∐ Nursing H y at	ome 5 Resid			0
ivisio	I or Attendater deat Director:	Certificate:	2 ☐ Accident Investigation 3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At hor building, etc. (Specify)				28f. Location (S City or Tow		er or Rura	l Route Number,
	To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	Medical	(Check 2 Medical Examin	cian: To the best of my knowle er: On the basis of examination Practitioner: To the best of m	and/or invest	igation, in my opinio	on, death occurred	at the time, date a	nd place, and du	e to the ca	use(s) and manner stated.
		2	29b. Signature and title of certifier		,	29c. License	e number		29d. Date signe	d (Month,	
U	Ch		30. Name and address of person who co	empleted cause of death (Item		rint)			,		
			Adam Sheely 27 S	32 Registrarie Signatur		rose Marylan	d 2(20)				
	Sta Registra		MAR 2 0 2012 A	32. Regisfrar's Signat							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Deat Physician/ 2012 Carolyn P. March Maurer 7:33 P M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Manor Care Woodbridge Valley Catonsville Baltimore 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) 8. Date of Birth June 4, 1930 If Under 1 Year If Under 24 Hrs. **Funeral** 9. Birthplace (State or Foreign Maryland 1 ☐ M 2🏋 F Days Director 214-26-2694 81 Yrs. Usual Residence of Decedent show 10a. State 10b. County notified at Director 10c. City, Town or Location 10d. Inside City Limits 28a-f Maryland Baltimore Catonsville 1 Yes 2X No 10e. Street and Number r must be r ò 10f. Zip Code 10g. Citizen of What Country? Funeral 1525 North Rolling Road 21228 United States Je filed with...
Aental Hygiene.
...ent, the Medical Examiner mr 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. þ 1 Never Married 2 Married 2 XNo Yes If Yes, Give Year or Dates 1 Yes 2 No Specify: White Completed 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) Nursing Assistant Hospital Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) should be file. h and Mental H 7 is marked ot မ Grev John other traumatic Dorothea Palm 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau once. Robert J. Maurer / Son 6340 Orchard Club Dr., Elkridge, Maryland 21075 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 D Burial 2 X Cremation 3 D Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory Inc. |03/19/2012 | Baltimore, Maryland 21. Signature of Funeral Service Licensee Alyson K 22. Name and Address of Facility Cremation Society of Maryland Inc Taylor 299 Frederick Road, Baltimore, Maryland 21228 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) -Zneme Medical Due to (or as a consequence of) Examiner Sequentially list conditions If any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): and I-transit that initiated events resulting in death) Last Due to (or as a consequence of) physician at the burial-Physician/Medical attending ph IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Live Birth 2 Fetal death Ectopic pregnancy in the past 12 months?
1 Yes 2 No Pregnant at time of death Month Day Year ned by the a detached f 1 ∐ Yes ∠ y 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by sign 1 be TEUMY ELITIS 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available 24a. Was an has autopsy performed Yes 2 prior to completion of cause of death?

1 Yes 2 No certificate 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital 1 \(\text{Yes} 2 No Other: 은 1 Inpatient 2 ER/Outpatient 3 DOA this 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death nours after death.

neral Director: After the filled in by the funeral 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at or Attending 28d. Describe how injury occurred 1 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No Accident
Suicide Investigation 6 Could not be 3 ☐ Suicide 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Hospital 24 hours Funeral Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a Certifier completed Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the I within 2 To the I 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

∱ Stat

Maryland 21215-0036

Baltimore,

Box 68760

P.O.

Records,

Vita

Division of

State ³ Registrar

NAR 2 0 2012 Annual Services Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MD

DHMH 17 Rev 7/2009

D005910

DRIVE

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Martha Month Marshall 5:15^AM 2012 March Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Timonium** 4c. County of Death
Baltimore **Examiner** Stella Maris Hospice Social Security Number 6, Sex If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) **Funeral** 7. Age (In yrs. last birthday) Days Hours Min 220-32-370 0 **Director** 1 □ M 2 🂢 F 84 June 22,1927 Baltimore, MD Usual Residence of Decedent 10a, State 10b. Count ms 23a or 28a-f sho must be notified at 10c. City, Town or Location 10d. Inside City Limits with the Maryland Director Baltimore MD Timonium 1 🗌 Yes 2 🛚 No 10e. Street and Number 10g. Citizen of What Country? Funeral 21093 2525 Pot Spring Road United States "natural", or item ledical Examiner n 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian ρ 1 Never Married 2 Married ☐ Yes 2 🔀 No Yes, Give Baltimore, Maryland 21215-0036 1 Yes 2X No Specify: Specify: White Completed 3 Widowed 4 Divorced Year or Dates Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) ed other than " event, the Med Union Memorial Elementary/Secondary (0-12) College (1-4 or 5+) Mental Hygiene. 12 Registered Nurse Hospital Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) of Health and Mental Fortem 27 is marked of tem 27 is marked or other traumatic ever မှ Stuart Wilson Egerton Katherine Lalor 2012 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Katie Magnuson-Daughter 3513 Sterling Ave. Alexandria, VA 22304 MARCH 19, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Department of H Important: If ite any injury or ot Evans Funeral Chapel - Bel Air March 1 Durial 2 X Cremation 3 Removal from State Forest Hill, MD 4 Donation 5 Other (Specify) 2012 21, re of Funeral Service Licensee 22. Name and Address of Facility Evans Funeral Chapel & Cremation Services 16924 York Road, Monkton, MD 21111 Pa 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, sh.ck, or heart failure. List only one cause on each line. Ir med ate Cause (Final Onset and Death Physician/ di easy or condition resulting in death) SEIZURE DISORDER Medical Due to (or as a consequence of **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): the burial-transi Cause (Disease or i that initiated events and Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical Box 68760 use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No 3 Cther (specify) ło Dav Pregnant at time of death ate has been signed by the a page 2 should be detached t Unknown 9 Unknown Division of Vital Records, P.O. MARTHA MARSHALL Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 🗖 Unknown 24b. Were autopsy findings available 24a. Was an After this certificate has prior to completion of cause of death? perform Yes 2 X No 2 No 1 Yes To the Hospital or Attending Physician: I within 24 hours after death.

To the Funeral Director, After this certifics completely filled in by the funeral director, I 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner?
1 Yes 2 No Hospital Other: မှ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Nother (Specify) HOSPICE 27. Manner of Death 28a. Date of injury 28b. Time of Certificate: 28c. Injury at work? 28d. Describe how injury occurred (Month, Day, Year) 1 X Natural 5 Pending injury 1 Yes 2 No 2 Accident Investigation 6 Could not be 3 Suicide 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 🗶 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie

State Registrar DHMH 17 Rev 06-2011 2300 DULANEY VALLEY RD.

2012

TIMONIUM, MD 21093

30. Name and address of person who completed cause of peath (Item 23a) (Type, Print)

CRNP

TRACIE L. MORGAN,

MAR 2 0 2012

31. Date filed (Month, Day, Year)

Physician/ Medical 4a. Fac **Examiner** 5. Soci **Funeral** Director Usua or 28a-f show 10a. St permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event. To Be Completed by Funeral Director 10e. St 11. Ma Baltimore, Maryland 21215-0036 17. Fat 3:00am Jol 19a. lr 20a. M -2012 21. Sig 23a. P Immed diseas resulti Physician/ 3-17 Medical **Examiner** Seque cause. Cause that in resulting Medical Certificate: To Be Completed by Physician/Medical Examiner within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed Tyrone Medin Division of Vital Records, P.O. Box 68760 IF FEM. 23b. W Part II. 25. Was exa 1 27. Ma 29a. C 29b. Si

31. Date filed (Month, Day, Year)

Please	Type or Pri						-		_	ble.	
For State Registrar	State of Ivi	arylanu / L	•	icate of L		iiu ivi		Reg. N	20	12	08651
1. Decedent's Name (First, Middle, Las Tyrone Junio	,	n					2. Date of Dea Month	ath	my -12	Year	3. Time of Death
4a. Facility Name (if not institution, give	street and number)		41	o. City, Town, or	Location of	Death		40	c. County o		UiW sam
2231 E. Madiso 5. Social Security Number 6. S		e (In yrs. last birti		Baltin Under 1 Year	ore	4 Uma	0.0 ((\perp	N/		
laca sá se el	M 2 □ F	47		onths Days	Hours	Min.	8. Date of Birt (Month, Day	y, Year)		Country	_
Usual Residence of Decedent 10a, State 10b, County		10c. City, Town	or Locatio	on		- 4	4-30-1	964	1	MI	d. Inside City Limits
MD N/A		Balt									1 X Yes 2 □ No
10e. Street and Number 2231 E. Madiso	n Street			10f. Zip Code 21205	<u> </u>			10g. C	itizen of Wh		ry?
11. Marital Status	12. Was Decedent E Armed Forces?	ver in U.S.		Decedent of Hi					14. Race	- Americar	
1 X Never Married 2 Married 3 Widowed 4 Divorced	1 Yes 2 If Yes, Give Year or Dates.	No		Yes 2 No		, dollo	nour, oto.y		Specify:	White, etc Bla	ack
15. Decedent's E (Specify only highest gr	ade completed)		(Give kind	's Usual Occup of work done o OT use retired)		of workin	ng	16b. I	Kind of Bus	iness/Indu	ustry
Elementary/Secondary (0-12)	College (1-4 or 5 N/A	+)		Impro	vemer	nt		Pr	ivat	:e	
17. Father's Name (First, Middle, Last)							(First, Middle,		Surname)		
Johnny Shinger 19a. Informant's Name/Relationship (7)	ine Print)	10h	Mailing A	ddress (Street a			Medli		a Tayun Cha	4- 7:- 0-	
Dorothy Young				lmora							
20a. Method of Disposition 1 ★ Burial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Specif	Removal from State		ry, cremato	on (Name of ory or other place Cemete			ate /2012		ocation - C	•	
21. Signature of Fineral Service Licens	see		22. Na		s of Facility	Mar	ch F/				E. Nort
23a. Part 1. Enter the disease, or com shock, or heart failure. List only o Immediate Cause (Final disease or condition resulting in death)	ne cause on each line		tage	e mode of dying	g, such as ca	ardiac or	respiratory arr	rest,		i i	Approximate nterval Between Onset and Death
Sequentially list conditions, and the cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c	consequence of								(5)	
IF FEMALE: 23b. Was decedent pregnant	d23c. If yes, outcome of								23d. Date	of deliven	
in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	1 ☐ Live Birth 4 ☐ Pregnant at 9 ☐ Unknown			topic pregnanc her <i>(specify)</i>	у				Monti		Day Year
Part II. Other significant conditions of	ontributing to death bu	ut not resulting in	n the unde	rlying cause giv	en in Part I.		23e. Did to	bacco	use contrib	ute to the	cause of death?
	rougeomic	unu	and.	K.			1 🗆 🗅	Yes 2	No 3	☐ Proba	ably 4 🗆 Unknown
						_			pride:	ere autops or to comp ath?	sy findings available pletion of cause of
25. Was case referred to medical examiner?					ace of Death	(Check		7			
1 ☐ Yes 2 ☐ No 27. Manner of Death		nt 2 ER/Out			4 🗀 Nurs		ne 5 Resid				
1 Natural 5 Pending 2 Accident Investigation 3 Suicide 6 Could not b							8d. Describe h	ow inju	ry occurred		
4 Homicide determined	28e. Place of Inju- building, etc		m, street,	ractory, office		2	8f. Location (S City or Tow			or Rural R	oute Number,
(Check 2 Medical Exami	sician: To the best of r ner: On the basis of ex se Practitioner: To the	amination and/or	r investigati	ion, in my opinio	n, death occu	urred at t	he time, date ar	nd place	e, and due to	o the cause	e(s) and manner stated
29b. Signature and title of certifier	la.			29c. License		àle-			ite signed (I		
30. Name and address of person who c			Гуре, Print) ВЭ	7 lens	den A	16	alh rei	0. 3	-1201	/	

DHMH 17 Rev 06-2011

State Registrar

32. Registrar's Signature

A. Amas

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 7:30 am ivian 2012 Medical As Facility Name (if not institution, give street and number)
Renaissance Garden City, Town, or Location of Death Examiner 4 County of Death Gardens 9. Birthplace (State or Foreign Country) Age (In yrs. last birthday, If Under 1 Year If Under 24 Hrs. **Funeral** 8. Date of Birth (Month, Day, Year) 550-38-1194 Director 1 🗆 M 2 📝 or 28a-f show e notified at within 72 hours after death with the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits **Funeral Director** MD Baltimore 1 Yes 2 No ō 10f. Zip Code must be r 10g. Citizen of What Country? 21215 deron items 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status Race - American Indian, Black, White, etc. "natural", or ite Armed Forces?

1 Yes 2 No Completed by 1 Never Married 2 Married 1 Yes 2 Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: 3 Midowed 4 ☐ Divorced Year or Dates je 1 and 2 should be filed within 72 hours t of Health and Mental Hygiene. If item 27 is marked other than "natur or other traumatic event, the Madical. 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life DO NOT use retired)

Librarian 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Be ther's Name (First, Middle, Last) 18. Mother's Name (First, Middle, မ xsu t's Name/Relationship (Type, Print Doughter City or Ton, State, Zip Code) 20910 1905 EIK oring, MD 20a. Method of Disposition 20b. Place of Disposition (Na Department or Important: If any injury or once. ō ■ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 21. Sign ure of Funeral Service L 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset Death Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed been signed by the attending physician and should be detached for use as the burial-trai that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?

1 Yes 2 No Month Year Dav Pregnant at time of death 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Completed 1 ☐ Yes 2 Z No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Director: After this certificate has autopsy performed? Yes 2 No 2 🗌 No 1 L Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 No Hospital: Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA 2Nursing Home 5 \square Residence 6 \square Other (Specify) funeral (27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred ✓ Natural injury work?
1 Yes 2 No 5 Pending ☐ Accident☐ Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) within 24 hours a Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check only one) Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Signature and title of certifie 29d. Date signed (Month, Day, Year)

DHMH 17 Rev 06-2011

State Registrar

			ase Type or P State of I							-		_	ble.	
	•	For State Registrar		,	•	rtificat				,	Reg. N	20	12	0865
Physicia	n/	1. Decedent's Name (First, Middle	•							2. Date of Do		av	Year	3. Time of Death
Medic	al	Norman Gene M		A		T				March		2012		9:19 P M
Examin	er	4a. Facility Name (if not institution 22104 Main Stre		7			Town, or $111{ m sb}$	Location	of Death			c. County c Carol:		
Funeral Director		5. Social Security Number 219–37–1311			ast birthday) 9 Yrs.	If Unde Months		If Under Hours	24 Hrs. Min.	8. Date of Bi January	rth		O Dietho	lace (State or Foreign Maryland
d t t	_	Usual Residence of Decedent 10a. State 10b. County		100 Cit	ty, Town or Lo	postion								Od. Inside City Limits
permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	Funeral Director		line		.1sbor)	0-1-							1 X Yes 2 □ N
vith th	rall	22104 Main Stre	et			10f. Zip	2164	1			10g. C	itizen of WI US		try?
eath v	Ľ.	11. Marital Status	12. Was Deceder		S. 13.	Was Deced	lent of His	spanic Orio	gin? (Spe	ecify Yes or No	-	14. Race		an Indian,
ifter d ", or i	≦	1 🕅 Never Married 2 🗆 Mar	If You Give	XNo		1 Yes, spec	**	n, Mexicar Specify:		Rican, etc.)		Black Specify:	, White, e	
ours a atural	eted	3 Widowed 4 Divorced	Year or Dates			edent's Usua		, , , ,			1.01		Whi	
n 72 h an "na Medi	Completed		est grade completed) College (1-4 of	ur 5.1)	(Give	kind of wo DO NOT use	rk done di	uring most	t of work	ing	160.1	Kind of Bus		
l withii ygiene her th t, the	ပ္မို	0				Ċ	lisab	led				neve	c MOI	ked
d be filec Mental H arked ot atic even	To Be	17. Father's Name (First, Middle, I Norman Gene Mo								e (First, Middle y Chamb				
shoul and l		19a. Informant's Name/Relations	hip (Type, Print)		19b. Mail	ing Address	(Street a	nd Numbe		d Route Numb				,
and 2 Health em 27 ther t		Brenda K. Barre 20a. Method of Disposition	tt/grandmot		2210 Place of Disp)4 Mai		reet		<u>illsbor</u>		Maryla Location - C		
age 1 ent of nt: If it y or o		1 Metriod of Disposition 1 Metriod of Disposition 2 □ Cremation 4 □ Depration 5 □ Other (S	3 Removal from Sta	ite C	cemetery, cre	matory or o	ther place			Date 0/2012				ryland
mit. Partme		21. Signature of Funeral Service		Тю	udon P	2. Name an				alling				
permi Depar Impo any ir once,		1 Aug 2	34			3111	Mou	ntair		ad Pasa				
		23a. Part 1. Enter the distase, or shock, or heart failure. List of	complications to caus only one cause on each	sed the deat ine.	h. Do not ent	ter the mod	e of dying	, such as	cardiac o	or respiratory a	rrest,			Approximate Interval Between
Physician/ Medical		Immediate Cause (Final disease or condition resulting in death)	a. Chr	ouic		irator	4	aile	~	and	Hy p	Pixc		Onset and Death
Examiner			Due to (or a	is a consequ	uence of): I	trac	hoo	e tron	414					
	ner	Sequentially list conditions, if any, leading to immediate	b. Due to (or a	is a consequ	uence of):	1140	<u> </u>	23 1070	5				\top	
xecuted n and al-transit	Examiner	cause. Enter Underlying Cause (Disease or iinjury that initiated events	o. Chron	ic to	achee	2 - br	on C	hifis						
e	_ 1	resulting in death) Last		ıs a consequ	1									
physic the b	edic		d. Bra	dyco	Jdia									
or Attending Physician: The law requires that the death certificate be after death. Director: After this certificate has been signed by the attending physicis in by the funeral director, page 2 should be detached for use as the but	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcon 1 Live Birt 4 Pregnan	h 2 🗌 Feta	al death 3	☐ Ectopic ¡☐ Other (sp		/				23d. Date Mont		ry Day Year
he de	hysi	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9 🗆 Unknow											
requires that the de been signed by the should be detached	ᇫ	Part II. Other significant condition	_			underlying (cause give	en in Part I	l.	23e. Did			oute to the	e cause of death?
aquires sen sig ould b	ted	Severe Me	ntal reta	rdatio	57					1 🗆	Yes 2	No 3	Prob	ably 4 D Unknowi
law re has be e 2 sh	Completed by									24a. Was	psy	pri	ere autop ior to con ath?	sy findings available opletion of cause of
sician: The law I certificate has b lirector, page 2 s		25. Was case referred to medical								1 \(\text{Yes}	ormed?		Yes 2	2 No
siciar s certif	To Be	examiner? 1 Yes 2 No	Hospital:	ationt 2	ER/Outpatie	nt 2 🗆 D(Othe	ce of Deat		me 5X Resi	danaa	6 D Other	(Cassiful)	
ig Phy er this neral c		27. Manner of Death	28a. Date of in	njury	28b. Time o		8c. Injury work?	at		28d. Describe				
eath. or: Af the fur	iica	Natural 5 Pendir 2 Accident Investig 3 Suicide 6 Could	gation	ruy, ruary	,	М		Yes 2 🗆	No					
or Att after d Direct in by 1	Certificate:	4 Homicide determ	ined 28e. Place of I	njury - At ho etc. <i>(Specify</i>		reet, factory	, office			28f. Location (City or To			or Rural I	Route Number,
	edical	29a. Certifier 1 Certifying (Check 2 Medical E	Physician: To the best xaminer: On the basis o	of my know	ledge, death	occured at	the time,	date and p	place, an	d due to the ca	ause(s) a	nd manner	as stated	l. se(s) and manner stat
thin 2 the F	Σ∣	only one) 3 Certifying 29b. Signature and title of certifier	Nurse Practioner: To t	ne best of m	y knowledge,	death occur	red at the	time, date	and plac	e, and due to the	ne cause	(s) and man	ner as sta	ted.
¥ ≥ ¥ 8		1057	1	MP		290			00		∠au. Da	ate signed (/_	uy, roar)
3 m		30. Name and address of person	who completed cause of			Print)	300	266	od 7:	٥		5/16	120	0/2
21.		FUNLOCA }	Famurius	503	5 CYN		DRI	UE, F	EAS	TON A	15	2160	1	
Stat Registra		NAR 2 U 2012 (Month 2012 (ear)	Server 32. Red	trar's gna	The state of the s			,						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Edith (nmn) Mitchell 2012 Medical March 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Upper Chesapeake Medical Center Bel Air Harford Social Security Number 6. Sex 8. Date of Birth (Month, Day, Year) If Under 24 Hrs. **Funeral** 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) Min. Days Hours **Director** 219-18-0510 1 🗆 M 2 🔀 F 87 Usual Residence of Decedent Apr. 13, 1924 Maryland or 28a-f show notified at with the Maryland 10a. State 10b. County 10c. City, Town or Location Director 10d. Inside City Limits 1 🗌 Yes 2 🔼 No Maryland Harford Churchville ö 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? r items 23a or ner must be Funeral 3006 Snake Lane 21028 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian. ian "natural", or ite Armed Forces?

1 Yes 2 No Black, White, etc. 1 Never Married 2 Married by If Yes, Give Year or Dates. 1 ☐ Yes 2 🔀 No Specify: Completed 3 Wildowed 4 Divorced White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Il Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) the Bookkeeper Farm Supply Be Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental F ၉ Herbert Mitchell Gorrell other traumatic Cordelia Amanda Mitchell 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If item 27 is any injury or other tra Judith M. Matthews / Daughter 21 Church St., Stewartstown, PA 17363 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1X Burial 2 ☐ Cremation 3 ☐ Removal from State Calvary U.M.C. Cem. 3-19-12 4 ☐ Donation 5 ☐ Other (Specify) Churchville, Maryland Funeral Service Licensee 22. Name and Address of Facility
MCComas Funeral Home, P.A.
1317 Cokesbury Rd., Abingdon, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final STROKE Phy ician disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** ~ Balange Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (visease or injury that initiated events Due to (or as a consequence of): Exami and burial-trai Due to (or as a consequence of): resulting in death) Last the attending physician Physician/Medical that the death certificate be the IF FEMALE 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death

4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No Day 1 Yes 2 9 Unknown 9 Unknown been signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an Were autopsy findings available prior to completion of cause of autopsy performe death? after death.

Director. After this certificate 1 Yes 2 No 1 Yes 2 No Vital To the Hospital or Attending Physician: Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner?
1 Yes 2 No Hospital Other: Certificate: To 1 Nnpatient 2 ER/Outpatient 3 DOA 4 \square Nursing Home 5 \square Residence 6 \square Other (Specify) 28a. Date of injury (Month, Day, Year) 28b. Time of 27. Manner of Death 28c. Injury at work?
1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred 1 Natural 5 Pending injury 2 Accident
3 Suicide
4 Homicide filled in by the Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. within 24 hours a Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) Medical Doctor 3/16/2012 D71096 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 520 upper Chesapeak prive Bel Ar, MO 21014 ANGELIM 32. Registrans Signature State Registrar

5

ED I LI

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Harry W. McClaskey, Sr. Physician/ March 15, 7:07 A Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner N/A Baltimore Union Memorial Hospital Social Security Number 8. Date of Birth (Month, Day, Ye January 28 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs 9. Birthplace (State or Foreign Sex 1XX M 2 □ F MD Country) **Funeral** Months Hours Min 212-32-4430 Director Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State with the Maryland notified at Director MD N/A Baltimore 28a-f 1XX Yes 2 ☐ No 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? ms 23a or must be n Funeral 21201 U.S.A. 524 N. Charles Street Apt. 1307 ural", or items ? I Examiner mus within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14 Bace - American Indian Armed Forces'

1 XX Yes 2 [
If Yes, Give Black, White, etc. 1 Never Married 2 Married þ 2 No Baltimore, Maryland 21215-0036 Specify: White 1 ☐ Yes 2 XXNo Specify: 52-55 "natural", Completed 3 Divorced 4 Divorced Year or Dates. the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry Elementary/Seconday (0-12) Mill Work than College (1-4 or 5+) permit. Page 1 and 2 should be filed with.
Department of Health and Mental Hygiene
Important: If item 27 is marked other thi
any injury or other traumatic event, the once. Carpenter Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) မ Elsie Mae Herman Ernest Henry McClaskey 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mary McClaskey (Wife) 524 N. Charles Street Apt. 1307 Balto, MD 21201 20a. Method of Disposition
1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) MD Veterans' Cemetery 3/19/12 Garrison Forest, MD 4 Donation 5 Other (Specify) Signature of Fune I S / 22. Name and Address of Facility Burgee-Henss-Seitz Funeral Home, Inc. 3631 Falls Road Balto, MD 21211 Part 1. Enter the disease, or combilications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate Examine Due to (or as a consequence of) to the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events physician and s the burial-trans Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 attending p IF FEMALE: ed by the attendin detached for use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Day Month Year 5 Other (specify) Pregnant at time of death 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed page 2 should 24b. Were autopsy findings available 24a, Was an prior to completion of death?

1 Yes 2 No has 1 Yes 2 within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: ᇋ 1 🗌 Yes 2 No 1 Inpatient 2 PER/Outpatient 3 IDOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Mann of Death 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred Natural 5 Pending work? Accident
Suicide 2 No Investigation Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one and title of certifier 29b. Signature

Registrar

DHMH 17 Rev 7/2009

State

M121234

and address of person who completed cause of death (Item 23a)

Month, Day, Yea NAR 2 0

			For State Registrar	State of Maryla		artment of H tificate of L		Mental Hy	giene Reg. No. 2	1 2	08656
	Physicia		1. Decedent's Name (First, Middle, Last) Howard	Maher				2. Date of De Month March	ath Day	Year 2012	3. Time of Death
0	Medic Examir		4a. Facility Name (if not institution, give s 5435 NELSON AVEN				Location of Dea		4c. Count		10:301
	Funeral Director		5. Social Security Number 214-34-4315 Usual Residence of Decedent	7. Age (In yrs	s. last birthday) Yrs.	If Under 1 Year Months Days	if Under 24 Hr Hours Mir				olace (State or Foreign (YLAND
	aryland a-f show fied at	ctor	10a. State 10b. County	10c. (City, Town or Loc			<u> </u>		1	0d. Inside City Limits
	h the Ma Sa or 28a be notii	Funeral Director	MD . 10e. Street and Number			BALT I			10g. Citizen of		•
	leath wit items 23 er must	Funer	5435 NELSON AVENU	12. Was Decedent Ever in U	J.S. 13. V	Vas Decedent of Hi Yes, specify Cuba		21215 Specify Yes or No-	14. Rad	USA ce - Americ	
9003	permit. Page 1 and 2 should be filed within 72 hours after death with the Mayland Department of Heath and Mental Hygiene. Important: I fire Z7 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	eted by	1 X Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	Armed Forces? 1 ☐ Yes 2 🛣 No If Yes, Give Year or Dates.	1	☐ Yes 2 🛣 No	Specify:	no Rican, etc.)	Bla Specify	ck, White, 6 /: WH]	
Maryland 21215-0036	thin 72 ho sne. than "na ne Medic	Completed	15. Decedent's Edu (Specify only highest grad	cation le completed) College (1-4 or 5+)	(Give k	ent's Usual Occup: ind of work done of NOT use retired)	during most of we	orking	16b. Kind of B		,
nd 2	e filed wirtal Hygie ed other event, tl	To Be (12TH 17. Father's Name (First, Middle, Last)			MAILE	18. Mother's Na	ame (First, Middle,	Maiden Surnam	INPAPE e)	IRS
aryla	hould be and Men s marke umatic		HOWARD E. MAHER 19a. Informant's Name/Relationship (Type	e, Print)	19b. Mailin	g Address (Street a	_	LYN A. PA		State. Zip C	Code)
re, M	l and 2 s F Health a tem 27 i		KATHLEEN MAHER 20a. Method of Disposition	SISTER	5102 Place of Dispos	KENWOOD	AVENUE	BALTO.	20c. Location	.06	
Baltimore,	it. Page ' rtment of rtant: If i njury or e		1 XBurial 2 Cremation 3 F 4 Donation 5 Other (Specify)	Removal from State	cemetery, crem SARDENS	or other place of the off off of the other off off off off off off off off off of	3-2	20-2012	BALTO.	MD.	
Ba	permii Depar Impor any in		21. Signature of Funeral-Service Licenser		22.			ROAD BAI			HOME, INC.
P	fryskolatu/		23a. Part 1. Enter the disease, o compli- shock, or heart faiture. List only one Immediate Cause (Final disease or condition	cations that caused the decause on each line.			g, such as cardia	c or respiratory an	rest,		Approximate Interval Between Onset and Death
	Medical Examiner		resulting in death)	Due to (or as a conse							
7	ansit	Examiner	Sequentially list conditions, if any, leading to himmediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a conse	querice of):						
Division of Vital Records, P.O. Box 68760	att certificate be executed attending physician and for use as the burial-transit	ical Ex	that initiated events resulting in death) Last	Due to (or as a conse	quence of):						· · · · ·
Box 68760	nding phy	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant 23	3c. If yes, outcome of pregr	nancy				23d Da	ite of delive	erv.
). Box	ed by the atte	hysicia	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	1 ☐ Live Birth 2 ☐ Fe 4 ☐ Pregnant at time o 9 ☐ Unknown		Other (specify)	у				Day Year
s, P.O.	signed b	by	Part II. Other significant conditions con	tributing to death but not re	esulting in the ur	derlying cause giv	en in Part I,				e cause of death?
Records,	has been si ge 2 should	Completed						24a. Was autop	an 24b.	Were autop	sy findings available inpletion of cause of
tal Re	is certificate hadirector, page	Be	25. Was case referred to medical examiner?			26. Pla	ace of Death (Che	1 Yes	2 No	1 Yes	2 No
of Vital	After this c	욘	27. Manner of Death	ospital: 1 ☐ Inpatient 2 ☐ 28a. Date of injury (Month, Day, Year)	ER/Outpatient 28b. Time of injury	3 DOA Othe	4 U Nursing at	Home 5 Resid			
Division	after death. Director: Af in by the fu	Certificate:	1 Natural 5 Pending 2 Accident Investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At I	nome, farm, stree	M 1□'	Yes 2 No	28f. Location (S	treet and Numbe	er or Rural	Route Number,
Div	124 hours after death		29a. Certifier 1 Certifying Physic	building, etc. (Speci	wledge, death or	ccurred at the time.	date and place.	City or Tow	uea(e) and man	ner as state	d.
o the Ho	within 24 ho	Medical	(Check 2 ☐ Medical Examine only one) 3 ☐ Certifying Nurse	Practitioner: To the best of	on and/or investi	ation, in my opinior	n, death occurred ne time, date and	at the time, date a place, and due to the	nd place and due	e to the cau nanner as si	se(s) and manner stated. tated.
	->-0		> n srujap			D00	5746	5		3/15/	
b			30. Name and address of person who cor	2835 Sm		5703 v	Ba Mmc	re MO	2120	9.	
ر ا	Stat Registra	e ir	MAR 2 0 2012 &	32. Registrar's Sign	are						
/ DHMH	H 17 Rev 06-2	011									

State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ . 2<u>012</u> Month Linda Jean McGuire March 16 8:20 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Montgomery Hospice Casey House Rockville Montgomery Social Security Number 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. Funeral Birthplace (State or Foreign Country) 8. Date of Birth Months Days (Month, Day, Year) Hours 215-68-9438 Director 1 🗆 M 2 💢 F 54 Dec. 11, 1957 Maryland Usual Residence of Decede show 10b. County notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 28a-f 1 Yes 2 X No Maryland Montgomery Gaithersburg 10e. Street and Number ò 10f. Zip Code 10g. Citizen of What Country? ed other than "natural", or items 23a or event, the Medical Examiner must be Funeral 704 Sunny Brook Terrace, Unit 1114 20879 United States 72 hours after death 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 2 X No Black, White, etc. þ 1 X Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 🕅 No Specify: If Yes, Give Year or Dates Completed 3 Widowed 4 Divorced Specify: White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working d Mental Hygiene. marked other than life. DO NOT use retired) Elementary/Secondary (0-12) 12 College (1-4 or 5+ Advocate Community Service of Health and Mental Hygiv of Health and Mental Hygiv fitem 27 is marked other Be 17. Father's Name (First Middle Last) 18. Mother's Name (First, Middle, Maiden Surname) ည John Thomas McGuire other traumatic Catherine Ruth Bowman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20879 Catherine R. McGuire/Mother 704 Sunny Brook Ter., Unit 1114, Gaithersburg, Saltimore, Date 22, 20a. Method of Disposition 20b. Place of Disposition (Name of Department of H Important: If ite any injury or ot 20c. Location - City or Town, State Page 1 1 X Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) March 2012 4 ☐ Donation 5 ☐ Other (Specify) Parklawn Memorial Park Rockville, Maryland Robert A. Pumphrey Funeral Home, Rockville, Inc. 300 W. Montgomery Avenue, Rockville, Maryland 20850 21. Signature of Funeral Service License within. A. Tu M01173 23a. Part 1. Enter the disease, or complications that daused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Physician Non-Hodgkins Lymphoma disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of): Exami Cause (Disease or injury Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): burial-t ending physician use as the burial Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? 1 ☐ Yes 2 X No 힏 Pregnant at time of death Month Day Year ed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. been signed to should be det 23e. Did tobacco use contribute to the cause of death? þ End Stage Renal Disease 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🔀 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an cate has page 2 s autopsy performe death? certificate 1 Yes 2 X No 2 No 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 1 Yes 2 🗶 No ဂ္ 1 Inpatient 2 I ER/Outpatient 3 I DOA 4 \square Nursing Home 5 \square Residence 6 \boxtimes Other (Specify) Hospice funeral c 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending work?
1 Yes 24 hours after death.
Funeral Director: Afetely filled in by the fu 2 Accident
3 Suicide
4 Homicide 2 🗌 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated within 2. 29b. Signature and title of certif 29c. License number 29d. Date signed (Month, Day, Year) D37142 March 16, 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Geoffrey Coleman, MD 1355 Piccard Drive, Suite 100, Rockville, Maryland 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar A parket

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death Day W. Meade, Sr. March

1 - For State Registrar 08658 1. Decedent's Name (First, Middle, Last) Physician/ Rodney 5:56 A Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Suburban Hospital Bethesda Montgomery If Under 1 Year | If Under 24 Hrs. Months | Davs | Hours | Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** 220-38-3814 Director 1 XM 2 □ F 71 Oct. 28,1940 Usual Residence of Decedent show 10a. State 10c. City, Town or Location notified at Director MD or 28a-f Prince George's Beltsville 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? must be by Funeral 23a 4700 Olympia Ave. 20705 United States or items death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian. traumatic event, the Medical Examiner Armed Force Black, White, etc. ☐ Yes 2 X No 1 Never Married 2 X Married within 72 hours after 1 Yes 2 X No Specify: White If Yes, Give "natural", 3 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) I Hygiene. other than " Air Conditioning and Elementary/Secondary (0-12) College (1-4 or 5+) 11 Self-Employed Heating Service Be Page 1 and 2 should be filed went of Health and Mental Hygant; If item 27 is marked oth 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Arthur Williamson Meade Lillian Emma 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sandra L. Meade / Wife 4700 Olympia Ave., Beltsville, MD 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 Burial 2 X Cremation 3 Removal from State Chesapeake Crematory 03/19/2012 4 Donation 5 Other (Specify) Beltsville, MD of Funeral Service Licenses Rapp Funeral Facility Cremation Services lice 40154 933 Gist Ave., Silver Spring, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition Ph_{sician} BRAIN TUMOR CHRONIC Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of): Cause (Disease or injury that initiated events resulting in death) Last attending physician and for use as the burial-tran Due to (or as a consequence of): Physician/Medical The law requires that the death certificate be 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

5 Other (specify) IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 ☐ Yes 2 ☐ No Day Month Vear 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>중</u> Completed 24a. Was an has autopsy perform Yes 2 X No 1 🗌 Yes Hospital or Attending Physician: 25. Was case referred to medical To Be 26. Place of Death (Check only one) examiner? 2 XNo Other: 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28h Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred X Natural 5 Pending 2 Accident
3 Suicide
4 Homicide 1 Tes 2 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined within 24 hours a 29a. Certifier Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29c. License number 2 29d. Date signed (Month, Day, Year)

9. Birthplace (State or Foreign Washington D.C. 10d. Inside City Limits 1 Yes 2X No Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? Division of 1XXCertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. D53177 MARCH 17, 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) M.D.; 9707 MEDICAL CENTER DR., ROCKVILLE, MD JOHN M. WALLMARK, 20878 31. Date filed (Month, Day, Year) NAR 2 0 2012 32. Registre 's Signa'u State Registrar DHMH 17 Rev 06-2011

			State of Maryland / De State of Maryland / De Registrar	oartment of Health a 0/2012dhb 27 pe ertificate of Death	and Mental Hyg er dr.	iene _{leg. No.} 20	12 0	8659
ı	Physicia		1. Decedent's Name (First, Middle, Last) Krishina Marie Mitchell		2. Date of Dea Month Februar	th Day	Year 3. Time	e of Death
	Medi Examir		4a. Facility Name (if not institution, give street and number) 213 S. Dallas Court	4b. City, Town, or Location o		4c. County 6		<i>70a</i> • ™
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday	Baltimore If Under 1 Year If Under 2 Months Days Hours	24 Hrs. 8. Date of Birth Min. (Month, Day,	Yearl	Birthplace (State Country)	te or Foreign
	Director show tat		219–70–2418 Usual Residence of Decedent 1 M 2 XF 51 Yrs.		09/05/		MD	
	darylan 8a-f sh tified a	Director	MD 10b. County 10c. City, Town or to Baltimo				22	City Limits Yes 2 \(\precedent\) No
	ith the N	ral Di	10e. Street and Number 213 S. Dallas Court	10f. Zip Code 21231		0g. Citizen of W	hat Country?	
	death w items a	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?	. Was Decedent of Hispanic Orig			- American Indian,	
980	s filed within 72 hours after death with the Maryland tal Hygiene. ed other than "natural", or items 23a or 28a-f sho event, the Medical Examiner must be notified at	ed by	1 ☐ Never Married 2 🕅 Married 1 ☐ Yes 2 🕍 No 1 ☐ Yes, Give Year or Dates.	If Yes, specify Cuban, Mexican, 1 Yes 2 No Specify:	, Puerto Hican, etc.)		Black	
21215-0036	72 hou in "natu Medical	Completed	(Specify only highest grade completed) (Giv	edent's Usual Occupation e kind of work done during most DO NOT use retired)	of working	16b. Kind of Bus	siness/Industry	
1212	ㅎ 골 든 ㅎ	Be Coi	9 U	nemployed				
/lanc	d be filed Mental Hy arked oth	To B	17. Father's Name (First, Middle, Last) Morris Thomas Mitchell Sr.	1	r's Name <i>(First, Middl</i> e, <i>N</i> se Collins M			
Man	12 should alth and Malth and Malth and Malth and Malth alth and Malth alth alth alth alth alth alth alth	ĮŠ.	19a. Informant's Name/Relationship (Type, Print) Arianne Williams – Daughter 241	ling Address (Street and Number 7 Annor Court,	or Rural Route Number, Baltimore ,	City or Town, Sta	ate, Zip Code)	
Baltimore, Maryland	Page 1 and 2 should be file ment of Health and Mental I- ant: If item 27 is marked of ury or other traumatic eve			position (Name of ematory or other place)		20c. Location - C	City or Town, State	
Balt	permit. Page 1 Department of Important: If i any injury or once.		21. Signature of Funeral Service Licensee Cullen Harris per DVR	22. Name and Address of Facility 5240 Reisterst	Chatman-Ha	rris Fu	neral Hon	
			23a. Part 1. Enter the disease, or complications that caused the death. Do not en shock, or heart failure. List only one cause on each line.				Approxim	nate
$\hat{}$	Physician/ Medical		Immediate Cause (Final disease or condition resulting in death) a. Due to (or as a consequence of):	disease			Onset an	
- 0	Examiner	er	Sequentially list conditions, b.					
	suted nd ransit	tamin	if any, leading to immediate audo. E. ner Underlying Cause (Disease or injury that initiated events				-	
0	cate be executed physician and the burial-transit	edical Examin	resulting in death) Last Due to (or as a consequence of): d	1				
68760	artificate ling phy se as the		IF FEMALE:		-			
). Box (To the Hospital or Attending Physician: The law requires that the death certifica within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending p completely filled in by the funeral director, page 2 should be detached for use as it.	Physician/M	23b. Was decedent pregnant in the past 12 morths? 1 ☐ Yes 2 ☐ Vio 9 ☐ Unknown 23c. If yes, outcome of pregnancy 1 ☐ Live Birth 2 ☐ Fetal death 3 4 ☐ Pregnant at time of death 5 9 ☐ Unknown	☐ Ectopic pregnancy ☐ Other (specify)		23d. Date Mont	of delivery h Day	Year
ds, P.O.	requires that the des been signed by the s should be detached	<u>۾</u>	Part II. Other significant conditions contributing to death but not resulting in the Diabette's Mellitus, Tenal	underlying cause given in Part I.	23e. Did tob		ute to the cause of	
Division of Vital Records,	The law re cate has be page 2 sh	Completed	HIV, Obesity, Hypery	tension,	24a. Was an autopsy perform	pri	ere autopsy findings or to completion of ath?	s available f cause of
tal B	cian: Th ertificate ector, pa		25. W.s. a refer medical scanninger?	26. Place of Death	77 1 Yes 2		Yes 2 No	
of Vi	ding Physician; 1 th. After this certifica funeral director, p	te: To	1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatie 27. Manner of Death 28a. Date of injury 28b. Time of	f 28c. Injury at	sing Home 5 Resider		(Specify)	
sion	ttendin death. stor: Aft y the fur	Certificate:	1 Natural 5 Pending (Month, Day, Year) injury 2 Accident Investigation 3 Suicide 1 Sui	M 1 ☐ Yes 2 ☐ N	40			
N N	spital or A ours after eral Dire filled in b		4 Homicide determined 28e. Place of Injury - At home, farm, st building, etc. (Specify)		City or Town,	State)	or Rural Route Nun	nber,
	the Hosp thin 24 hor the Fune upletely fi	Med	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death points of examination and/or investigation on the basis of examination and/or investigation on the best of my knowledge.	stigation, in my opinion, death occure, death occurred at the time, date	urred at the time date and	place and due to	the equec(e) and m	nanner stated.
—	P N P N		29b. Signature and title of certifier	29c. License number	7103 (d. Date signed (f	Month, Day, Year)	
			30. Name and address of person who completed cause of death (Item 23a) (Type,	Print)	0	21.1	16	
P	State	е	31. Date filed (Modth Day, Year). 32. Registrar's Signature	119/11/	<i>O</i> ,			——
	Registra	r	- Bear					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2012 2. Date of Death

			1 - For State Registrar	State of iv	iai yiai iu	•	tificate c			vieritai ny	Reg. N	20	2	08660
Г	Physicia	ın/	Decedent's Name (First, Middle, Table 1. Decedent's Name (First, Middle, Table 2. A. Marie (First, Middle)	Last)						2. Date of De Month March	ath	ay oo Y	ear	3. Time of Death
· Lange	Medic Examin	al	Joyce A. Mays 4a. Facility Name (if not institution,	give street and number)			4b. City, Tow	or Locatio	n of Death	March		201		9:04 A M
· Same	LAGIIII	iei	13500 Orion Dri				Daytor		n or boatin		40		ward	
	Funeral	Г	5. Social Security Number		ge (In yrs. last	birthday)	If Under 1 You Months Da	ar If Unc	ler 24 Hrs.	8. Date of Bir (Month, Da	th Vear			lace (State or Foreign
	Director		229-56-0013 Usual Residence of Decedent	1 🗆 M 2 🕱 F	69	Yrs.		, , , , , , ,		March 25		2 V	irgi	
	and show	ē	10a. State 10b. County		10c. City, To	own or Loc	ation							Od. Inside City Limits
	Maryl 28a-f stified	Director	Maryland How	ard		Day	ton							1 Yes 2 No
	th the		10e. Street and Number				10f. Zip Cod				10g. C	itizen of Wha		try?
	ath wil	Funeral	13500 Orion Drive	12, Was Decedent	Ever in 119	12 1/	Van Danadant i	21036	Origin 2 (Sp.	poify Von or No		U.S.		
9	er deg or ite miner	by Fi	11. Marital Status 1 ☐ Never Married 2 🕱 Marri	Armed Forces?						ecify Yes or No- Rican, etc.)		14. Race - Black,	America White, e	
003	urs aft ural", il Exal		3 Divorced	If Yes, Give Year or Dates.		1	☐ Yes 2 🛣	No Spec	ify:			Specify:	W	nite
21215-0036	72 hou n "nat ledica	Completed	15. Decedent (Specify only highes		1	(Give k	ent's Usual Oci ind of work do	ne during m	ost of work	ing	16b. l	Kind of Busir	ness/Ind	ustry
212	vithin jene. er tha		Elementary/Secondary (0-12)	College (1-4 or	5+)	House) NOT use retii wife	ea)				Ox	vn Ho	me.
	filed valued by all Hyg	Be (17. Father's Name (First, Middle, La	st)	,					e (First, Middle,	Maiden			
yla	Ment Ment narke	은	John Miller					Sar	rah Ehe	eart				
Maryland	2 shorth and th and the results to the traum		19a. Informant's Name/Relationshi Douglas Mays	p (Type, Print) (Husband)						al Route Numbe			e, Zip Ci	ode)
	f Heal item a		20a. Method of Disposition		20b. Plac	e of Dispos	Orion Dri			Maryland Date		.oçation - Ci	ty or Tov	wn, State
m 0	Page nent o ant: If Iry or		1 X Burial 2 Cremation 4 Donation 5 Other (Sp	3 ☐ Removal from State	Columb	* '	norial Pa		3–21-	-2012	Cla ₁	rksville	e. Ma	rvland
Baltimore,	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		21. Signature of Funeral Service Lie	ensee		22.	Name and Ad	dress of Fac	eility Wit	zke Fune:	ral F	lames.	Inc.	
		Н	23a. Part : Enter the disease, or o	complications that cause	d the death F)).	DOD TMTU	KNOLLS	Koad	Columbia	a, Ma	aryland	2104	
	The second second		shock, or heart failure. List or Immediate Cause (Final	lly one cause on each lin	e.						iest,			Approximate Interval Between Onset and Death
	Medical		disease or condition resulting in death)	a. Due to (or as	a consequent	1771/hz	FIBR	0515	OF	LUNUS			- 3	34197CS
	Examiner		Sequentially list conditions,	h RH	runt?	OTO	FIBR	42175					19	Interval Between Onset and Death
	d sit	Examiner	if any, leading to immediate cause. Enter Underlying	Due to (or as	a consequen	ce of):								
	and II-tran	Exar	Cause (Disease or injury that initiated events resulting in death) Last	c. Due to (or as	a consequent	ce of):							+	
0	cate be executed physician and s the burial-transit	ical	1	d.										
8760	tificate ng phy as th	Physician/Medical	IF FEMALE:											
39 ×	th cer ttendii or use	ian/	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome 1 Live Birth	2 Fetal de	eath 3 🗌						23d. Date of		
P.O. Box	re dea the a	ysic	1 ☐ Yes 2 🗷 No 9 ☐ Unknown	4 ☐ Pregnant a 9 ☐ Unknown	at time of deat	th 5∟	Other (specify)				WORL		Day Year
P.0	that th	by Pr	Part II. Other significant condition	0		ng in the ur	nderlying cause	given in Pa	rt I.	23e. Did to	obacco	use contribu	te to the	e cause of death?
ds,	quires en sign	ed k	DIABLE	MELLIN	3					1 🗆	Yes 2	▼ No 3	Prob	ably 4 🗆 Unknown
CO	aw red las ber 2 shr	Completed	HYPERT	NSON						24a. Was	osy	pric	r to com	sy findings available inpletion of cause of
Re	: The law cate has I									perfo 1 ☐ Yes	rmed? 2 N	dea lo 1 🗆		2 □ No
ţa	Physician: T r this certifica eral director, p	m	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No	Hospital:			Ta	. Place of D Other:						
of \	g Phy er this neral d	:e: To	27. Manner of Death	28a. Date of inju		b. Time of	28c, li	4 ∐ njury at		me 5 Resid 28d. Describe h			Specify)	
O	endin eath. or: Aft	ficat	1 Natural 5 Pending 2 Accident Investiga	ation	y, rear)	injury	M 1	ork?	□No					
Division of Vital Records,	or Att	Certificate:	3 ☐ Suicide 6 ☐ Could no 4 ☐ Homicide determin		ury - At home c. <i>(Specify)</i>	, farm, stre	et, factory, offi	ce		28f. Location (S City or Tow			r Rural f	Route Number,
	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit		29a. Certifier 1 🔀 Certifying F	Physician: To the best of	mv knowledo	e. death o	ccurred at the	ime, date a	nd place, a	nd due to the ca	ause(s) a	and manner:	es state	
	he Ho in 24 h ne Fur pletely	Medical	(Check 2 Medical Ex	aminer: On the basis of e lurse Practitioner: To th	examination an	d/or investi	gation, in my or	inion, death	occurred at	the time, date a	ind place	e, and due to	the caus	se(s) and manner stated.
	To the community of the the community of the the community of the the community of the	_	29b. Signature and title of certifier	1/.				ense numbe				ite signed (N		
D			* Euch	pll-				1594	7		mA	cit 1	6,2	2012
)			30. Name and address of person of war and address of person of the second of the secon					TZ. 10	<u>ن</u> ن	LINES	n	no 21	0dF"2 \	
	Stat	e	31. Date filed (Month, Day, Year)	. 32. Registra	ar's Signature	1		· · / ~ ·		-way		in ar	9) 1	<u> </u>
	Registra	ır	MAR 2 0	2012 /	N A.	100	Mar							

DHMH 17 Rev 06-2011

			State of Maryland / Dep		•	•	- 0 1
			Registrar 1. Decedent's Name (First, Middle, Last)	rtificate of Death	2. Date of Dea	Reg. No. 2	11866 L
ш	Physicia Medic		Annabelle L. Novicki			15, Day 2012 Year	3. Time of Death 4:20 P M
4	Examir		4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Death	
	Formani		Arden Courts 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	Towson If Under 1 Year If Under 24 Hrs.	8. Date of Birth	Baltimore	
	Funeral Director		218-03-4701 1 DM 2 ME	Months Days Hours Min.	(Month, Day	(Year) Count	_
	nd at	Ŀ	Usual Residence of Decedent 10a. State 10b. County 92 Yrs. 10c. City, Town or Le		July 29	·	Maryland Od. Inside City Limits
	/larylar 8a-f sl tified	Director	MD Baltimore Towson			["	1 Yes 2 X No
	a or 2 be no		10e. Street and Number	10f. Zip Code		10g. Citizen of What Coun	
	ms 23 must	Funeral	8101 Bellona Avenue	21204		USA	
9	er des or ite miner	by Fu	1 Never Married 2 Married 1 Yes 2 X No	Was Decedent of Hispanic Origin? (Spe If Yes, specify Cuban, Mexican, Puerto	Rican, etc.)	14. Race - America Black, White, e	
003	urs afi tural", al Exa		3 X Widowed 4 ☐ Divorced If Yes, Give Year or Dates.	1 ☐ Yes 2 ☐ Xo Specify:		Specify: whi	te
21215-0036	within 72 hours after death with the Maryland giene. er than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at	Completed	(Specify only highest grade completed) (Give	dent's Usual Occupation kind of work done during most of worki OO NOT use retired)	ing	16b. Kind of Business/Ind	ustry
212	iled within I Hygiene. other thai ent, the N		Elementary/Secondary (0-12) College (1-4 or 5+) Homema			Own Home	
Maryland	1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene, item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	To Be	17. Father's Name (First, Middle, Last) unk	18. Mother's Name	e (First, Middle, N	Maiden Surname)	
aryl	should be fil n and Mental ' is marked raumatic ev			ng Address (Street and Number or Rura	al Route Number.	City or Town State Zio C	ode)
	and 2 st Health a em 27 is ther tra		A. Michael Pateris / son 13620	O Bardon Road; Pho			
Baltimore,	ge 1 and 2 of Healt ilitem 2 or other		TE Buildi 2 E Orgination o E nemovarioni state	matory or other place)	Date	20c. Location - City or Tov	vn, State
İţir	permit, Page 1 a Department of H Important: If ite any injury or ott		4 Donation 5 Other (Specify) Hilltop	Service Corp. 3/19 2. Name and Address of Facility	/2012	Towson, MD	ork Road
ñ	permit. Departr Importa any inju			uck Towson Funeral	Home,		, MD 21204
			23a. Part 1. Enter the disease, or complications that caused the death. Do not ent shock, or heart failure. List only one cause on each in	er the mode of dying, such as cardiac o	or respiratory arre	est,	Approximate Interval Between
	Physician Medical			tin-Alzhe	mers		On let and De III
	Examiner		Due to (or as a consequence of):			10	
		iner	if any, leading to immediate cause. Enter Underlying				
	be executed sician and burial-transi	Examiner	Cause (Disease or injury that initiated events resulting in death) Last C. Due to (or as a consequence of):				
0	te be executed nysician and he burial-transit	ical	d.				
876	tificate ng phy e as th	Med	IF FEMALE:				
Box 6876	eath certificate attending phy d for use as the	cian/	23b. Was decedent pregnant 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 3 in the past 12 months?	Ectopic pregnancy Other (specify)		23d. Date of deliver	y Day Year
Ö.	the deg ny the g ached	by Physician/Med	1 Yes 2 No 4 Pregnant at time of death 5 L 9 Unknown 9 Unknown	Unier (specify)		No.	July Tour
0	requires that the des been signed by the s should be detached		Part II. Other significant conditions contributing to death but not resulting in the t	underlying cause given in Part I.		pacco use contribute to the	
rds	require been si should	eted					ably 4 🗌 Unknown
Division of Vital Records,	The law ate has the page 2 s	Completed			24a. Was ar autops perforr	prior to com med? death?	sy findings available pletion of cause of
a B	siclan: The certificate irector, pag		25. Was case referred to medical	26. Place of Death (Check	1 Yes :	2 No 1 Yes 2	2 □ No
Ξ	Physician: T r this certifica aral director, p	욘	examiner? 1		me 5 Reside	ence 6 Other (Specify)	Living,
0 U	ding F th. After funer	cate	27. Manner Death 1 Natural 5 Pending 2 Accident Investigation 28a. Date of injury (Month, Day, Year) (Month, Day, Year) 28b. Time of injury	28c. Injury at work? M 1 ☐ Yes 2 ☐ No	28d. Describe ho	w injury occurred	FACILITY
risio	al or Attending P s after death. I Director: After t d in by the funera	Certificate:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e. Place of Injury - At home, farm, str		28f. Location (Str	reet and Number or Rural F	Route Number,
á	pital or ours aft eral Dir filled ir	- 1			City or Town		
	Hos Han Hely tely	Medical	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death of the best of my knowledge, death of the best of my knowledge only one) 3 Certifying Nurse Practitioner: To the best of my knowledge	tigation, in my opinion, death occurred at	the time, date an	d place, and due to the caus	se(s) and manner stated.
	To the within 2 To the comple	5	29b. Signature and title officertifier				
			My thony theley, un	1 1993 902	/	MARCHI	10012
			30. Namedand address of penson who completed cause of death (lytem 23a) (Type, F	29c. License number D25205 Print) N-Charles S	St. Ball	to. md 21	20%
	Stat	_	31. Date filed (Month, Day, Year) NAR 2 0 2012 August 32. Registrar's Signature				
	Registra	r	MARKULUIC KENNE D. Galle				

		_ For	Pleas	se Type or F State of			artment of h		-		egible.	
	•	State Registrar				Ce	rtificate of l	Death		Reg. No. 2	012	08662
Physicia		1. Decedent's Name	e (First, Middle,	LAWRENC	E P	HILIP	OLIVE	R	2. Date of De Month March	Day	2012	3. Time of Death 11:50 PM
Medic Examin		4a. Facility Name (if	not institution,	give street and number		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		r Location of Death			unty of Death	
		Frederi	ck Memo	rial Hospi	ital		Freder	rick	*	F	rederio	:k_
Funeral Director		5. Social Security No. 578–40–86		6. Sex 1 X M 2 D F	Age (In yrs. Ia		If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da July 4	y, Year)	1 Count	lace (State or Foreign ty) igan
now at	ī	Usual Residence of 10a. State	Decedent 10b. County		10c. City	y, Town or Lo	ocation				10	0d. Inside City Limits
Marylar 28a-f sl otified	irecto	MD	Freder	ick		mont						1 ☐ Yes 2X No
with the s 23a or ust be r	Funeral Director	10e. Street and Num 10610 Pot		ad			10f. Zip Code 21788			10g. Citizen USA	of What Coun	try?
permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	þ	11. Marital Status 1 ☐ Never Marri 3 ☐ Widowed		12. Was Decede Armed Force 1 1 Yes 2 If Yes, Give Year or Date	s? □ No (ur	۱۲۱	Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 XNo	an, Mexican, Puerto			Race - America Black, White, e	etc.
2 hour	Completed	(Spe	15. Decedent	's Education t grade completed)		16a. Dece	edent's Usual Occup	pation	kina	16b. Kind	of Business Inc	lustry
hin 72 ne. than	mo:	Elementary/Seco		College (1-4	or 5+)		OO NOT use retired)		•		ture Re	
Hygien ther int, th	Be C	17. Father's Name (#	First Middle La	5±		Owner	r	18. Mother's Nan				upholster
be file ental i ked c	To I	James Ol:		31/				Susan Ri	- '	waden sum	iarrie)	
2 should Ith and M 27 is mar traumat		19a. Informant's Na Evelyn R	me/Relationshi				ing Address (Street O Powell	and Number or Ru	ral Route Numbe			ode)
ige 1 and nt of Hea t: If item		20a. Method of Disp	oosition Cremation	3 ☐ Removal from St		Place of Disp	osition (Name of matory or other plac urney Cre	cel	Date	20c. Locati	ion - City or To	
nit. Pa artme ortan injury		4 ☐ Donation 21. Signatume of Fur	5 Other (Sp		1 - 1 - 1							
Depar Impo any ir		Deve	I LI	o litte	MO1	251 B	2. Name and Addre Olng Home everly I.	Crematio	on Servi	.ce P. Clark	.O. Box ssville	784 , MD 21029
				complications that cau	sed the death							Approximate
Physician/		Immediate Cause (I	Final	A	SPIR	ITA.	ON	PNEI	MONL	Ail	1	Interval Between Onset and Death
Medical Examiner		resulting in death)	-	a	as a consequ		•					
	J.	Sequentially list cor		b. ——								
sit sd	Examiner	if any, leading to im cause. Enter Under Cause (Disease or i	rlying	Due to (or	as a consequ	ience of):						
be executed sician and burial-transit	Exal	that initiated events resulting in death) L	5	c. Due to (or	as a consequ	ience of):						
be esisiciar burit	cal			L _d								
ificate ig phy as the	Med	IF FEMALE:		1								
To the Hospital or Attending Physician: The law requires that the death certificate b within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physicompleted filled in by the funeral director, page 2 should be detached for use as the beautified in by the funeral director, page 2 should be detached for use as the beautified in by the funeral director, page 2 should be detached for use as the beautified in by the funeral director, page 2 should be detached for use as the beautified in by the funeral director, page 2 should be detached for use as the beautified in by the funeral director, page 2 should be detached for use as the beautified in by the funeral director, page 2 should be detached for use as the beautified in by the funeral director, page 2 should be detached for use as the beautified in by the funeral director, page 3 should be detached for use as the beautified in by the funeral director, page 3 should be detached for use as the beautified in by the funeral director, page 3 should be detached for use as the beautified in by the funeral director, beautified in by the funeral director by the funeral director beautified in by the funeral director by the funeral director by the funeral director by the funeral director by the funeral directo	Physician/Medi	23b. Was decedent in the past 12 r 1 Yes 2 9 Unknown	months?		th 2 ☐ Feta nt at time of d	aldeath 3	☐ Ectopic pregnand ☐ Other (specify)	ру		23d.	. Date of delive Month	ery Day Year
that the ned by a detain		- 1		s contributing to dea	th but not res	ulting in the	underlying cause gi	ven in Part I.	23e. Did to	obacco use c	contribute to th	e cause of death?
quires en sig suld b	ted t	PRIMAI	1	ILIARY	01	KKH	TIVE !	1 000	1 🗆	Yes 2 N	lo 3 🗆 Prob	pably 4 Unknown
he law rei te has be age 2 sho	Completed by	CHRONIC	c My	ELOPRO	LIF	ERA	TIVE	DISORDI	perfo		4b. Were autop prior to cor death? 1 Yes	osy findings available inpletion of cause of
ian: T rtifica ctor, p	Be C	25. Was case referre	ed to medical				26. P	lace of Death (Chec		2 K INO	T L Tes	2 LI NO
hysic his ce I direc	To E	1 ☐ Yes 2 🔀	K No	Hospital:	patient 2 🗌	ER/Outpatie	ent 3 DOA Oth	er: 4 Nursing H	lome 5 Resid	dence 6 🗌	Other (Specify)	
nding Pl ath. r: After the e funeral	Certificate:	27. Manner of Death 1 Natural 2 Accident	5 Pending		injury <i>Day</i> , Yea <i>r)</i>	28b. Time o injury	work		28d. Describe h	now injury occ	curred	
ital or Atte		3 ☐ Suicide 4 ☐ Homicide	6 ☐ Could no determin	28e. Place of	Injury - At ho etc. (Specify,		reet, factory, office		28f. Location (\$ City or Tov		imber or Rural	Route Number,
n 24 hou e Funer	Medical	(Check 2	☐ Medical Ex	Physician: To the best aminer: On the basis Nurse Practioner: To	of examination	and/or inves	stigation, in my opinio	on, death occurred a	at the time, date a	and place, and	d due to the cau	se(s) and manner stated.
Vithir Comp	2	29b. Signature and		Λ.			29c. License		<u> </u>		gned (Month, E	
		> 00	um	most	M	D	D 5	2880,	8	C	3/16	15015
lot Sm		30. Name and addre	ess of person w	RUSU 4	to li	Jest	7+h S	t Fred	erick	MD	2170)(
Stat Registra		31. Date filed (Month	h, Day, Year) 2 0 2012	32. Reg	istrar's Signat	ture	,	-		-1		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Dary1 I. 01son March 2012 P Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Washington Adventist Hospital Takoma Park Montgomery Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) June 20, 1 6. Sex . Age (In yrs. last birthday) **Funeral** 9. Birthplace (State or Foreign 1 💢 M 2 🗆 F Days Hours 37 Yrs. **Director** 550-33-2320 California 974 Usual Residence of Decedent or 28a-f show notified at filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location Director 10d. Inside City Limits MD Prince George's Hyattsville 1 Yes 2 No 10e. Street and Number ò 10f. Zip Code must be n 10g. Citizen of What Country? Funeral 2718 Kirkwood Place #304 20782 United States items 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No "natural", or item ledical Examiner n Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. ģ 1 X Never Married 2 Married 1 Yes 2 If Yes, Give Year or Dates. Maryland 21215-0036 1 ☐ Yes 2 🕅 No Specify: White Completed 3 Widowed 4 Divorced the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) ntal Hygiene. ed other than " event, the Mec Elementary/Seconday (0-12) College (1-4 or 5+) 12 Self-Employed Caregiver Healthcare Be permit. Page 1 and 2 should be filed Department of Health and Mental Hy Important: If item 27 is marked out any injury or other traumatic event 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Ivan 01son Roger Stephanie Amber Ackermann 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Stephanie Grado / Mother 11463 Alder Creek Ave., Corona, CA Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Durial 2 X Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Chesapeake Crematory 03/20/2012 Beltsville, MD Signature of Funeral Service Licensee ²² Rapp and Address of Facility Rapp Funeral and Cremation Services elice Nº3 1015 Ave., Silver Spring, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final MONAR Physician/ disease or condition Medical resulting in death) Examiner to (or as a consequence of): NEUMONIA Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine Due to (or as a consequence of): MHUNE the Hospital or Attending Physician; The law requires that the death certificate be executed and burial-tran Due to (or as a consequence of) resulting in death) Last attending physician for use as the burial Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months? Month Day Year 2 No been signed by the should be detached g 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has performed within 24 hours after death.

To the Funeral Director: After this certificate I completed filled in by the funeral director, pagr 2 No Yes 2 1100 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital 2 1 No 1 Tes Certificate: To ER/Outpatient 3 DOA 1 Impatient 2 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending work?
1 Yes 2 No 1 Natural injury ☐ Accident ☐ Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 - Homicide Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signatur and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar 31. Date filed (Month, Day, Year,

DHMH 17 Rev 7/2009

ADVENTUT

WASHINGTON

22. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2012

HOSPITAL, TAMOMA

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Mary Marlene Perticone March P3 2012 04:40 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Anne Arundel Medical Center Annapolis Anne Arundel Social Security Numbe 7. Age (In yrs. last birthday, If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Feb. 28 Birthplace (State or Foreign Country) **Funeral** 1 - M 2 X Months Days Hours 216-40-5303 Director 1945 67 Feb. Usual Residence of Decedent or than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10a. State 10b. County within 72 hours after death with the Maryland 10c. City, Town or Location Director 10d. Inside City Limits Maryland Anne Arundel Annapolis 1 Tes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Completed by Funeral 556 Choptank Cove Court 21401 USA 12. Was Decedent Ever in U.S. 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian Armed Forces?

1 Yes 2 No
If Yes, Give 1 Never Married 2 Married Black, White, etc. Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: White 3 XWidowed 4 ☐ Divorced Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Cosmetologist 12 <u>Hairdressing</u> Be be filed 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Herman Murray permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any injury or other traumatic. Mary Honeycutt 19a Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Cinthia Bergey 2406 Valentine Drive, Bumpass, VA 23024 (daughter) 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State March 20 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) cemetery, crematory or other placel Maryland Veterans Cemi 2012 Crownsville, Maryland Signature of Funeral Senice License 22. Name and Address of Facility Stallings Funeral Home, P.A. 3111 Mountain Road, Pasadena, MD 21122 23a. Part 1. Enter the aons that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Part 1. Enter the disease, or o shock, or heart failure. List or Approximate Interval Between Onset and Death cause on each line Immediate Cause (Final Ph sician/ COPD disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): or Attending Physician: The law requires that the death certificate be executed ng physician and as the burial-trans Cause (Disease or finjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 nding p IF FEMALE nse s 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 Wo
9 Unknown for Pregnant at time of death Month Day Year the a ed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? signe I be d þ Completed Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s has performe certificate 1 ☐ Yes 2 ☐ No Yes 2 No 25. Was case referred to medical director, Be 26. Place of Death (Check only one) examiner?
1 Yes 2 No P Other: ✓ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) After this 28a. Date of injury (Month, Day, Year) filled in by the funeral 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending injury work? 1 ☐ Yes 2 ☐ No To the Hospital or Attendia within 24 hours after death. To the Funeral Director: At Investigation 6 Could not be 3 Suicide 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office bullding, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a Certifier completed (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title 29d. Date signed (Month, Day, Year) 72199 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dr Kanak Patel 2001 Medical Pkwy. Annapolis,MD 21401 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene **1 –** For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Joseph Phair Month Year W. 8:39 2012 Morch Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore Union Memorial Hospital 5. Social Security Number 1kn 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** Hours Country) Director 1X M 2 □ F 09 47 MD 64 13 Usual Residence of Decedent or than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1X Yes 2 ☐ No Baltimore MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21212 U.S.A. 811 Cator Ave death 12. Was Decedent Ever in U.S 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14 Race - American Indian Armed Force Black, White, etc. þ 1 XNever-Married 2 Married Yes 2 X No hours after Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Black If Yes, Give Year or Dates 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) Disabled Disabled 12th Grade na other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Harriet McCloud Raymond Phair 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 st Department of Health ar Important: If item 27 is any injury or and 811 Cator Ave, Baltimore, Md 21212 Betty Phair-Sister 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 X Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) Memorial Park 3/24/2012 Woodlawn, Md Donation 5 - Other (Specify) King 22. Name and Address of Facility March F/H West 4300 Wabash Ave, Signature of Funeral Service Licenses Baltimore, Md 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear dailure. List only one cause on each line. Onset and Death Immediate Cause (Final Phylician and color moner Arrest disease or condition resulting in death) Medical Due to (or as a contequence of): **Examiner** 1755-18:29 MI Uke Sequentially list conditions, if any course to underlying cause (Disease or injury Due to lor as a consequence of physician and strans that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical or Attending Physician: The law equires that the death certificate be P.O. Box 68760 as IF FEMALE: nse 23b. Was decedent pregnant 23d. Date of delivery for in the past 12 months?

1 Yes 2 No Year Dav 1 Yes 2 L g Unknown the þ t een signed I should be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available 24a. Was an s certificate has t director, p. ge 2 s prior to completion of cause of death? perform 1 Yes 2 No Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital Other: 2 No 2 1 ☐ Inpatient 2 Ø ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of I Director: After to d in by the funeral Certificate: 28c. Injury at 28d. Describe how injury occurred work?
1 Yes 1 Natural 5 Pending M 2 🗌 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined within 24 hours a

To the Funeral C

completely filled filled Hospital Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and tit o 007229

Registrar

State

E. Universit

Baltimore.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

201

Kolovida

Umar

31. Date filed (Month, Day,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 19 Josephine Schnabel Point 2012 March 5:25 AMMedical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner **Baltimore** Towson Gilchrist Center If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, **Funeral** Day, Year, Hours 212-30-4664 **Director** 1 □ M 2 🕅 F 87 May 21, 1924 Germany Usual Residence of Dec 28a-f show 10a. State 10c. City, Town or Location 10d. Inside City Limits at Director be notified 1 Tyes 2 No Maryland Baltimore Towson 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? ō 23a Funeral United States 21286 Examiner must 300 E. Joppa Rd. items within 72 hours after death v Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. o þ 1 Never Married 2 Married 2 X No 1 ☐ Yes If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. "natural", Specify. white 3 X Widowed 4 Divorced Completed Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. College (1-4 or 5+) Elementary/Secondary (0-12) medical nurse Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Magdalena Pickartz Peter Schnabel 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health a Important: If item 27 is any injury or other tra 21234 15 Joni Ct. Baltimore, MD Rosemary Krecz/daughter 20a, Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 🗌 Burial 2 💢 Cremation 3 🗌 Removal from State Mar. 20,2012 4 ☐ Donation 5 ☐ Other (Specify) Green Mount Crematory Baltimore, Maryland 122 Name and Address of Facility, Funeral Service of Dulaney Valley, Tohn O. Mitchell IV, Funeral Service of Dulaney Valley, P.A. P.A. P.A. 21. Signature of Funeral Service License Pay 1. Enter the disease, or compl shock, or heart failure. List only on rations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, use on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician disease or condition resulting in death) Medical **Examiner** Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events Due to (or as a consequence of): Exami The law requires that the death certificate be executed and -tran Due to (or as a consequence of): resulting in death) Last burialattending physician for use as the buria Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Year Month Day Pregnant at time of death Unknown þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No page 2 this certificate 2 No 1 Yes Hospital or Attending Physician: 25. Was case referred to medica Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2**X** No 140sdice မ 1 Inpatient 2 ER/Outpatient 3 DOA funeral 27. Manner of Death 1 Natural 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred : After t Certificate: 5 Pending work 1 Yes 2 No after death. Accident Suicide within 24 hours after death

To the Funeral Director: A

completely filled in by the Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number, Homicide

building, etc. (Specify)	City or	Town, State)
19a. Certifier 1 Certifying Physician: To the best of my knowledge, death of (Check 2 Medical Examiner: On the basis of examination and/or investigation of the basis of examination and/or investigation of the basis of my knowledge, and the basis of	gation, in my opinion, death occurred at the time, da	te and place, and due to the cause(s) and manner stated.
9b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
IVI.D.	78£1500Q	3-19-12

State Registrar

Medical

Name and address of person who completed cause of death (Item 23a) (Type, Print)
WWP Shaveen, 6701 N. Cheeles St. #4105, Baltimelle, MD 21204

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death March 18, Day 2012 Year Physician/ 6:45 Paul Robert Prentice Рм Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Frederick 5615 Mountville Road Adamstown If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Hours Aug 18, 1927 287-24-4953 Director 1**X** M 2 □ F 84 Ecuador Usual Residence of Decedent show 10d. Inside City Limits aţ 10b. County 10c. City. Town or Location Director notified or 28a-f 1 Yes 2X No MD Frederick Adamstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Examiner must be 23a Funeral 5615 Mountville Road 21710 USA items death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? 14. Race - American Indian, Black White etc. "natural", or 1 Never Married 2 XMarried þ ☐ Yes 2X No Yes, Give within 72 hours after Maryland 21215-0036 1 ☐ Yes 2 XNo Specify. Specify. Completed 3 Widowed 4 Divorced White Year or Dates traumatic event, the Medical 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) than " Elementary/Secondary (0-12) College (1-4 or 5+) and Mental Hygiene. 5+ Non-profit Organization Consultant Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Emmanuel Prentice Edna Garnet Hanna 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sl Department of Health a Important: If item 27 is Joseph Bartl/spouse 5615 Mountville, Rd. Adamstown, MD 21710 other Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place)

Final Journey Crematory 03/20/12 20a. Method of Disposition 20c. Location - City or Town, State 9 1 Burial 2X Cremation 3 Removal from State Woodbine, MD injury o 4 Donation 5 Other (Specify) 22. Name and Address of Facility
Coing Home Cremation Service Signature of Funeral Service Lice any P.O. Box 784 MO1251 Beverly L. Heckrotte, P.A. MD 21029 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) a Ischemic Cardiomyopathy 10 years Medical Due to for as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) burialinding physician a use as the burial Physician/Medical death certificate be Box 68760 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ atten for u in the past 12 months?
1 ☐ Yes 2 ☐ No Month Year Pregnant at time of death the the 1 ☐ Yes 2 L 9 ☐ Unknown g Unknown P.O. ed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? signed l þ 1 Yes 2 No 3 Probably 4 Yunknown Acute Renal Failure, COPD, Chronic Hepatitis C, Division of Vital Records, Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Hypothyroid page 2 s autopsy performed? certificate 1 ☐ Yes 2 ☐ No Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) or Attending Physician: Be examiner? Other: 4 \square Nursing Home X Residence 6 \square Other (Specify) Hospital 1 Yes 2 **X** No 1 Inpatient 2 ER/Outpatient 3 DOA To the Hospital or Attending Phys within 24 hours after death.

To the Funeral Director; After this of completely filled in by the funeral di 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred Certificate: 5 Pending injury 1X Natural Accident
Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 29a. Certifier X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 3 only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certified 29c. License number

13 8/

Registrar

DHMH 17 Rev 06-2011

State

Andrew Donelson, M.D. 65C Thomas Johnson Drive Frederick, mD 21702

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year

MAR 2 0 2012

D21936

March 19, 2012

		For		State of	Marylanc		artment of I		and Me	ental Hy	giene	e	0	00000
		State Registrar		4)		Cer	tificate of l	Death			Reg. N	o. ZUI	4	nappo
Physic	cian/	Decedent's Nam		,						2. Date of De Month	D	ay Yea	ar	3. Time of Death 1:00 PM
	dical		not institution, give		er)		4b. Citv. Town. o	r Location o	of Death	M		18, 2 c. County of D		1.00 1
Exam	mer	, ,	iew Care				4D. Oity, lown, o	Ess			-	Balti		9
Funer	al	5. Social Security N	umber 6. S	ex 7.	Age (In yrs. las	t birthday)	If Under 1 Year	If Under		8. Date of Bir		9.	Birthplac	ce (State or Foreign
Directo		217-14-		□ M 2 F	90	Yrs.	Months Days	Hours	IVIII.	(Month, Da	05,	1921	Mary	yland
nd how at	۲	Usual Residence	10b. County		10c. City,	Town or Loc	cation						10d	. Inside City Limits
larylar 3a-f s ified	Funeral Director	MD	 Balti	more	E	ssex								1 Yes 2 No
the Mor 28		10e. Street and Nur					10f. Zip Code				10g. C	itizen of What	Country	?
with s 23a ust b	era	1 Easte	ern Blvd				2122	21				United	Sta	tes
ABIVIANG Z1Z13-UU30 should be filed within 72 hours after death with the Maryland n and Mental Hygiene. r is marked other than "natural", or items 23a or 28a-f show raumatic event, the Medical Examiner must be notified at	Fur			12. Was Decede Armed Force	es?	13. V	Vas Decedent of H	lispanic Orig	gin? (Speci	fy Yes or No- can, etc.)		14. Race - A Black, W		
after after I", or xamin	à		ied 2 Married	1 Tes 2 If Yes, Give	Mo No		☐ Yes 2 No					Specify:		
Z15-UU36 in 72 hours after e. an "natural", o Medical Exam	Completed	3 🗆 Widowed	15. Decedent's E	Year or Date	s.	16a Deced	ent's Usual Occup	nation			16h	Kind of Busine		hite
713 72 h an "n	am	(Spe	cify only highest gn		0.51)	(Give I	aind of work done of NOT use retired)	during most	t of working	7	100.	KING OF BUSINE	555/11 IQUS	ou y
withir spiene giene er that, the	ပိ		ondary (0-12)	College (1-4	01 5+)	Sea	mstress					Clothi	ng	
nd filed doth	Be		First, Middle, Last)					18. Mothe	er's Name (First, Middle,	Maider	n Surname)		
yland Ild be filed Mental Hy narked oth	٩	Frank	Jacob					St	ue Bu	irgess				
Mar 2 shou th and 27 is m traum		19a, Informant's Na			19		g Address (Street							de)
ire, Maryla t and 2 should be f Health and Men item 27 is marke other traumatic		20a. Method of Disp	Tyson /Gr	andson	20h Pla		4 Baysid	e Dr.			· · · ·	MD 21 Location - City		State
baltimore, N permit. Page 1 and 2 Department of Health Important: If item 27 any injury or other t		1 🗌 Burial 2	🔀 Cremation 3 🗆		tate cer	metery, cren	natory or other pla	i		Mar 21	١.	•		
IITIN nit. Pa artme ortani injury	الم	4 ☐ Donation 21. Signature of Fu	5 Other (Special	.,			ake Crem Name and Addre			2012		Beltsvi	.iie,	Maryland
Dep Dep any	ouce	▶ Robo	26	- DOL MA	MOISE	3	Crematio	on and	Funer				1	4 01006
			he disease, or com			Do not ente	8717 Gre or the mode of dyir					vson Mai	A	pproximate
- Physician	<i>i</i>	Immediate Cause		11	No. Person		Ginay U	lan Bar	· · ·				O	nterval Between
Medica	al	disease or condition resulting in death)		a. ue to (or	as a conseque	nce of):	CHILD U	raceon	Lycar				+	12007
Examine		Sequentially list co	nditions	h										
7 5	Examiner	il any, leading to in cause. Enter Unde	rlying	Due to (5r	as a conseque	nce c.)								
ecuted and trans	xan	Cause (Disease or that initiated event resulting in death)	injury s	C. Due to for	as a conseque	nce of:							-	
rou cate be executed physician and s the burial-transit	<u>8</u>	resulting in death)	Last	. Due 10 (01	as a conseque	noc oij.								
route by physics the t	edical			d									\pm	
DIVISION Of VITAL RECORDS, F.O. BOX 00/100 To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transi	Physician/M	IF FEMALE: 23b. Was decedent	pregnant	23c. If yes, outco			1				ļ	23d. Date of	delivery	
death of the atterned for a	icia	in the past 12 1 Yes 2	months?	4 Pregna	nt at time of de		Ectopic pregnan Other (specify) _	cy				Month	Da	ay Year
the d by the	hys	9 Unknown		9 🗌 Unknov					_					
s that the	by F	Part II. Other signif		ontributing to dea	th but not resul	ting in the u	nderlying cause gi	ven in Part	1.					cause of death?
dS, equire	ted	Teriaci		1 .						1 🗆	Yes 2	2 ∐ No 3 L	J Probab	oly 4 Unknown
COL	Completed by	Depue	1000 Hom	10 his						24a. Was auto	psy	prior	to comp	findings available detion of cause of
VICAL MECOTOS, ysician: The law requires s certificate has been sig			Hovetice R	Moran C	reace					1 Yes	ormed?	death No 1 🗆	Yes 2	□ No
ician: certifia	Be	25. Was case referr examiner?		Hospital:			Oth	lace of Dear						
Phys Phys this eral dii	<u>اء</u>		J√No n	1 In 28a. Date of	patient 2 E	R/Outpatien	t 3 DOA 28c. Injur	4 (11)		e 5 🗌 Resi		6 Other (S)	pecify)	
on of the standard of the stan	Certificate:	1 Natural 2 Accident	5 Pending Investigation	(Month,	Day, Year)	injury	wor			ia. Describe i	now inju	ny occurred		
Atten Atten r dea sctor: by the	ŧ	3 Suicide	6 Could not b	e 28e. Place of		ne, farm, stre	eet, factory, office		28			nd Number or	Rural Ro	oute Number,
DIVISION OF all or Attending Ph s after death. I Director: After th ed in by the funeral				building	, etc. (Specify)					City or Tov	wn, Stat	e)		
ospit hour unera	Medical	29a. Certifier 1	Certifying Phy											e(s) and manner stated
the H nin 24 the Fu	Mec		Certifying Nur				death occurred at	the time, da			the caus	se(s) and mann	er as stat	ted.
Vith Vith		29b. Signature and	title of certifier				29c. Licens	_				ate signed (Mo		
			recel (Li	esolut	<i>)</i>			1667				3-19-	201	
		30. Name and addr	1)),	completed cause	of death (Item 2	23a) (Type, P	rint) 1#508	31.2	779-1-2	Maula	us	2106	,	
	tate	31. Date filed (Mont	h, Day, Year)		istrar's ∡ 6ignatu	me The	10 508	· VCH /	N. NEV.	11-0[0,00	6	
Regis		MAR	2 0 2012	Deneur	istrar's 6ignatu	ack								
					- 1									

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Amend Item 25 per me, g925,03/19/2012dhb Certificate of Death Reg. No. Dededent's Name (First, Middle, Last) 2. Date of Death Payne Physician/ MMC Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Deat Examiner Secon 20 If Under 1 Year If Under 24 Hrs. Social Security Number 6. Sex 8. Date of Birth Birthplace (In yrs, last birthday **Funeral** 1 □ M 2 🕱 F Months Days Hours Min. Wonth, Day **Director** 28a-f show 10a. State 10b. Count 10c. City, Town or Location permit, Page 1 and 2 should be filed within 72 hours after death with the Maryland 10d. Inside City Limits other traumatic event, the Medical Examiner must be notified at Director 1 Fes 2 No MOVE 23a or 2 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 2121 anu items 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 1 No If Yes, Give Year or Dates. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. ō Completed by 1 ★ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔼 No Specify: Black 3 Widowed 4 Divorced "natural", 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) d Mental Hygiene. marked other than College (1-4 or 5+) Elementary/Seconday (0-12) resser 10 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden St မ ayne 19a. Informant's Name/Relation ip (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) SOKS Department of Health al Important: If item 27 is any injury or other trau 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or offer 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 2012 21. Signature of Funeral Service Licensee 701 23a. Part 1. Enter the disease, or complications that can sed the death. Do not enter the ode of dvina a cardiac or respiratory arrest Approximate shock, or heart failure. List only one cause Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine burial-transit Cause (Disease or iinjury that initiated events and Due to (or as a consequence of): resulting in death) Last CERTIFICATION APPROVED BY MEDICAL EXAMINER ed by the attending physician detached for use as the buria Physician/Medical the Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 months
1 Yes 2 No Month Day Year Pregnant at time of death Unknown 9 Unknown the Funeral Director: After this certificate has been signed by impleted filled in by the funeral director, page 2 should be detact other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by nertimeters 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b Were autopsy findings available prior to completion of cause of autopsy performe death? 1 Yes Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital Other: 2 1 No ည 1 ☐ Inpatient 2 ☑ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify, 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred injury 1 Natural 5 Pending Investigation Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) completed filled in by 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within To the and title of certifier 29d, Date signed (Month, Day, Year) 29b. Signature, 29c. License number 30. Name and address of person cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month, Day, Year)

Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1. Decedent's Name (First, Middle, Last) **Physician** PATCHETT ETHEL /Medical 4a. Facility Name (If not institution, give street and number) Examiner PERRING GENESIS 5. Social Security Number 6. Sex **Funeral** 1 □ M 2 🗹 F 94 Director 212-20-700 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. 10a. State 10b. County or than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at Director BALTIMORE MD 10e. Street and Number Funeral 3304 HONEYSUCKLE LANE 11. Marital Status 1 ☐Yes 2 X No If Yes, Give 1 Never Married 2 Married Maryland 21215-0036 Completed by 3 XWidowed 4 ☐ Divorced Year or Dates 15. Decedent's Education (Specify only highest grade completed) al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) of Health and Mental H litem 27 is marked oth r other traumatic even 17. Father's Name (First, Middle, Last) Be **PEDERSON** EMILE ပ 19a. Informant's Name/Relationship (Type. Print) Department of Health a Important: If item 27 is any injury or other trace EDWARD CAVANAUGH/SON Baltimore, 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral 8 vice Licensee Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Examiner Examiner burial-transi

4.15PM 03 2012 4 4b. City. Town, or Location of Death 4c. County of Death USA PAKKWAY BALTIMORE 8. Date of Birth (Month, Day, If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) Months Days Hours Min. Country) MARYLAND 05/06 10d. Inside City Limits 10c. City, Town or Location 1 ☐ Yes 2 No MIDDLE RIVER 10g. Citizen of What Country? 10f. Zip Code 21220 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2**X**☐ No Specify. Specify: WHITE 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) HOUSEWIFE DOMESTIC 18. Mother's Name (First, Middle, Maiden Surname) CHRISTINA MURPHY 19b, Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 303 STALLINGS, TAYLORS, SOUTH CAROLINA 29687 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State BAYVIEW CREMATORY 3/16/12 BALTIMORE, MARYLAND 22. Name and Address of Facility LILLY & ZEILER INC. FUNERAL HOME 1901 EASTERN AVENUE, BALTIMORE, MD 21231 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. nocrardial Due to (or as a consequence of) DONGLA Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of): Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 🗆 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 3 Probably 4 ☐ Unknown 1 □ Yes 2 □ No 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed?

1 □ Yes 2 □ No 1 ☐Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1∐Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28d. Describe how injury occurred 5 Pending investigation Natural 1 ☐Yes 2 ☐ No 2 Accident 6 ☐ Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 🔁 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

Certificate of Death

2. Date of Death

Month

Day

Year

3. Time of Death

or Attending Physician: The law requires that the death certificate be executed and P.0. Division of Vital Records, this death. after death within 24 hours a

the use as

be detached

funeral director, page 2 should

filled in by

completely

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DATWOOD ROAD Olen Pournie im Worker Jude 31. Date filed (Month, Day, MAR 2 0 201 **ORIGINAL**

State Registrar

2-0215 4 ylvia Clarice Re		Please Typ St 1- For State	ate of Maryl	and / Dep		of Health a			giene	/I 	20	12	2 0867
Physicia	_	Registrar 1. Decedent's Name (First, Middle)	le,Last)			, Doda,			2. Date of De			;	3. Time of Death
ledical Exami		Sylvia Claric							Month March 15				1240 hrs
		4a. Facility Name (if not institution 9300 Blk Piney Brance)	_	umber)		4b. City, Town, Silver Spr		n of Death			. County of I		
Funeral		5. Social Security Number	6. Sex	7. Age (In yrs	. last birthday)	If Under 1 Yo		nder 24Hrs.	8. Date of B		-	•	place (State or
Director		212-21-0151	1 M 2 √ F		23 Y	Months Da	ays Hou	ırs Min.	March		F	oreign	^{ntry)} Maryland
	ŀ	Usual Residence of Decedent	·		25				THEFT	1 17	1700		
w any		10a. State 10b. County		10c. Cit	ty, Town or Loc								10d. Inside City Limits 1 Yes 2 No
Aaryland 28a-f show 1 at once.	ţ	Maryland Mon	tgomery		Si]	ver Spr.				10a Citi	zen of What		
e Mary or 28a	Director		3							rog. Cit.		Courin	ı y r
death with the Maryland or items 23a or 28a-f sho must be notified at once.		10310 Royal Ro		cedent Ever in	U.S. 13. W	2090 as Decedent of F		rigin? (Sp	ecify Yes or N	lo-	USA 14. Race - A	America	an Indian, Black,
leath v	Funeral	1 Never Married 2 M	arried Armed F			Yes, specify Cub	an, Mexica	an, Puerto	Rican, etc.)		White, 6	etc.	
after c	Dy F		orced If Yes, Give Ye or Dates:	ar		Yes 2∑ N						Whi	
hours fratur		 Decedent's Education (Spe Elementary/Secondary (0-12) 		1-4 or 5+)		ent's Usual Occup most of working li				16b. F	(ind of Busin	ness/Ind	dustry
36 hin 72 e. e. edical	ple	Elementary/Secondary (0-12)	1	1-4 01 3+)	C	erk				Gr	cocery	St	ore
5-00 ed with tygien other	Completed	17. Father's Name (First, Middle,	Last)				18.Moth	er's Name	(First, Middle				
21215-0036 uld be filed within 7 Mental Hygiene. marked other than	å	Willie Lee Ja							Katheri				
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once	입	19a. Informant's Name/Relations Fred Miller Re		ndfatha	1.4	ng Address (Str							Zip Code)
MD and 2 sho tealth and tem 27 is traumati	H	20a. Method of Disposition	erri, Gra		. Place of Dispe	Spearposition (Name of o		DEIVE	Date	20c.	Location - C	ity or T	own, State
Baltimore, permit. Pages 1 and Department of He Important: If ite injury or other tr		1 Burial 2 X Cremation		rom State	crematory or o	ematory	Inc.	03/1	17/12	l Ra	altimo	re	Maryland
altin nit. Partme sortan	Н	4 Donation 5 Other Si 21. Signature of Funeral Service		as Greg	22	Name and Addre	ee of Eaci	lity					- taly land
	8 9	Thomas &	MA		1 1 2	remation 199 Fred	n Soc erick	ciety Roac	or Mar 1 Balt	cylar Limoi	nd, In ce. Ma	c. rvl	and 21228
Physician M		23a. Part I. Enter the disease, or failure. List only one cause	complications that on each line.	caused the dea	th. Do not enter	the mode of dyin	g, such as	cardiac or	respiratory a	rrest, sho	ock, or heart		Approximate Interval Between Onset and
xaminer	1	Immediate Cause (Final disease or condition resulting in death)										-	Death
			b.	a consequence	3 OI).								
	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause		a consequence	of):								
0.2	Examiner	(Disease or injury that initiated events resulting in death) Last	C.	a consequence	of):			100				- "	
executed an and al - transit			d									_	
	dical	UNPENDED	AMENDED										
cath certificate be est attending physicia for use as the buria	Ž	IF FEMALE: 23b. Was decedent pregnant in th		outcome of pre		etal death	Ecto	pic pregna	ncv	230	d. Date of de Month	livery Da	y Year
x 68 th certi	cia	past 12 months?	4 Preg	nant at time of	J # - =	Other (Specify)				ļ			
BO) he death the att	Physician/Med		known 9 Unkr		t rooulting in the	Lindadirina saus	a alvan in	Port I	23e Did	tobacco	use contribu	te to th	ne cause of death?
P.O. B that the d med by the	2	Part II. Other significant condit	ions contributing	o death but no	t resulting in the	driderlying causi	a giveiriii	raili.			No 3		
rds, P.C requires that been signed I hould be deta	Completed	-				· · · · · · · · · · · · · · · · · · ·			24a. Wa				ppsy findings available
Cords law require has been e 2 should	ם								perf	opsy formed?	dea	th?	mpletion of cause of
of Vital Reciting Physician: The I. After this certificate I funeral director, page		25. Was case referred to medica	<u> </u>			26.Pla	ce of Deal	th (Check o	1 Yes	2 N	0 1	Yes	2 No
Vita ysicia his cer direct	To Be	examiner? 1 ✓ Yes 2 No	Hospital: 1	Inpatient 2	ER/Outpatie	nt 3 DOA	Other ₄	Nursing	Home 5	Reside	nce 6 🗸	Other:	Scene
of ing Ph After t uneral		27. Manner of Death	28a. Date	e of Injury h Day Year) , 2012	28b. Time of	Injury 28c. Ir	ijury at Wo	ls	28d. Describe				truck truck
ttendi death.	atio	1 Natural 5 Pend 2 ✓ Accident Inve	stigation		1232 hrs		Yes 2	No					
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physici completely filled in by the funeral director, page 2 should be detached for use as the buint	Certification:	dete	ld not be			eet, factory, office	e building,	- 1	28f. Location or Town, 9300 blk Pin	State)			al Route Number, City Spring MD
lospits F hours uners		4 Homicide 29a. Certifier	hysician: To the be		ad / Highwa		date and						
To the How within 24 h	Medical		miner:On the basis and manner	of examination									
8 4 8 4	Æ	29b. Signature and title of certific	A .		1000	29c. Lice	nse numb	er		29d.	Date signed	(Mont	h, Day, Year)
		Outer Va	tor V.	eld	150	0.0	C.M.E.			Mar	ch 16, 20	12	
2		30. Name and eddress of person				A/ Dalati	Ct	Dali	n MD 241				
	لب	Victor Weedn MD JD	Assistant M	edical Exam		W. Baltimore	Street,	Baitimoi	re, MD 212	223			· · · · · · · · · · · · · · · · · · ·
Si Regis	tate trar	31. Date filed (Month, Day, Year)	1 32. F	Legistral 3 digiti									
DHMH 17 Rev 1/2	001	MAK 2 U 2012	COME !	p. 19	ORIGIN	AL							
OCME 2006				-									

Registrar

LOPPAINE OFFI AWUAH, ND, 5430 CAMPBELL BLVD, STE 214, BALT, MORE ND H236

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year)

		For	State of Maryland		ment of Fi Sicate of E		lental Hyg	iene		00670
1 - State Registrar				Reg. No. 2 U			08613			
Physicia Medic		1. Decedent's Name (First, Middle, Last) Ly dia M	MARTIN REID				2. Date of Death Day 62012			3. Time of Death 950A M
Examin		4a. Facility Name (if not institution, give str 8821 Winands	eet and number)	AL A	City, Town, or	Location of Death		4c. County of	Death	·
Funeral Director		5. Social Security Number 6. Sex	7. Age (In yrs. last		Under 1 Year onths Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,		9. Birthpla Countr	ace (State or Foreign y)
land show d at	or	Usual Residence of Decedent 10a. State 10b. County	10c. City,	Town or Location	on,		9141	912		d. Inside City Limits
e Maryk r 28a-f s notified	Director	MD Baldim 10e. Street and Number	ore Kan		DWn Of, Zip Code			0g, Citizen of Wh	-1.0	1 Yes 2 No
h with th ns 23a o nust be	Funeral	8821 Winands.	Road		2,	1133		US/		y <i>!</i>
re, Maryland 21215-0036 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. item 27 is marked other than "natural", or items 23a or 28a-f sho other traumatic event, the Medical Examiner must be notified at	by	11. Marital Status 1 □ Never Married 2 □ Married 3 ☑ Widowed 4 □ Divorced	2. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates.	If Yes	Decedent of His, specify Cubar	spanic Origin? (Spe n, Mexican, Puerto I Specify:	cify Yes or No- Rican, etc.)	14. Race - Black, Specify:	White, et	
21215-0036 within 72 hours after glene. er than "natural", o the Medical Exam	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)		(Give kind	's Usual Occupa of work done d OT use retired)	ation Juring most of working	ng	16b. Kind of Busi	ness/Indu	ustry
d 21 ed with Hygien other th	Be Co	17. Father's Name (First, Middle, Last)		Home	mak	18. Mother's Name	e (First, Middle, N	1)0 m	est	ic
Maryland 2 should be filed the and Mental Hy 27 is marked oth traumatic event	υ		obs			Evada	Nel	Brown		
e, Ma and 2 sho Health and em 27 is in		19a, Informant's Name/Relationship (Type YVULLE Brown	1. 1.	19b. Mailing A	1 1	and Number or Rura	Da C K	7 / //	' ' <i> </i> ' '	n MO3/133
O 0 = 5		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Re 4 ☐ Donation 5 ☐ Other (Specify)	emoval from State 20b. Place cen	1 1 1 1	on (Name of ary or other place UUUA	e) 3-23	Date -	20c. Location - C	ity or Tow	M, State
Baltimo permit. Page Department o Important: If any injury or		21. Signature of Funeral Service Licen e	une		ame and Addres	s of Facility aug		ene Fune allstow		
		23a. Part 1. Enter the disease, of complic shock, or heart failure. List only one Immediate Cause (Final	ations that caused the death.			g, such as cardiac o			7	Approximate nterval Between Onset and Death
Medical Examiner	8 0	disease or condition resulting in death)	Due to (or as a consequer	y Sen nce of):	-9					
	iner	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):								
executed in and ial-transi	Examiner	Cause (Disease or injury that initiated events c. Due to (or as a consequence of):								
. 68760 certificate be ording physicial use as the but	edical	d.								
Box death he atte	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	c. If yes, outcome of pregnance 1 Live Birth 2 Fetal c 4 Pregnant at time of dea 9 Unknown	death 3 🗆 Ec	stopic pregnanc her (specify)	у		23d. Date Month		y Day Year
cords, P.O. law requires that the nas been signed by the e 2 should be detach	by	Part II. Other significant conditions cont	ibuting to death but not result	ing in the unde	rlying cause giv	en in Part I.		eacco use contribu	_/	use of death?
S S S S	Completed						24a. Was ar autops perform 1 \(\sum \text{Yes}\) 2	v prid	re autops or to com ath? Yes 2	y findings available pletion of cause of
Vital vsician; s certific director,	To Be	25. Was case referred to medical examiner? 1 Yes 2 No	spital:1	B/Outpatient 3	Othe	er:		nce 6 🗆 Other	(Specify)	
n of ding Ph		27. Mann → of Death 1 Natural 5 ☐ Pending 2 Accident Investigation		8b. Time of injury	28c. Injury work	at		w injury occurred		
Division of all or Attending Plus after death. Safter death. Director: After the funerated in by the funerates.	Certificate:	3 Suicide 6 Could not be determined	28e. Place of Injury - At home building, etc. (Specify)				28f. Location (Str City or Town	reet and Number of, State)	or Rural F	Poute Number,
Division of Vital Rec to the Hospital or Attending Physician; The la within 24 hours after death. To the Funeral Director. After this certificate ha completely filled in by the funeral director, page.	Medical	(Check 2 Medical Examine	an: To the best of my knowled : On the basis of examination a	nd/or investigat	ion, in my opinio	n, death occurred at	the time, date and	d place, and due to	the caus	e(s) and manner stated.
To the within ?	M	only one) 3 L Certifying Nurse I 29b. Signature and title of certifier	Practitioner: To the best of my	knowledge, dea	29c. License		2:	9d. Date signed (Month, Da	ay, Year)
7		30. Name and address of person who con	ipleted cause of death (Item 2)	3a) (Type, Print)	1019	2/2	2/	Merchi	CI	2012
<u>5</u>		31. Date filed (Month, Day, Year)		和海	Lian	Blud	den!	BURNIE	0 6	1061
Stat Registra		MAR 2 0 2012	Ceron B.	park	1					

			Ple	ase Type or AMENI State of Item 29d	Print in ITEM#	Black II 20a-c, 2 nd ZDep	ndelible li 22perFH, adment of	n k. Ensu r G925, 372 Health ar	e All Copi 28 / 20 I 2 W nd Mental H	es Are S vaiene	<mark>e Legi</mark> k e	ole.	
		-	State Amend Registrar	Item 29d	per dr.	, g925; Ce	03/20/20 rtificate of	Death		Reg. N	o. 2 N	12	08674
			1. Decedent's Name (First, Midd						2. Date of I	2. Date of Death 3. Time 6			
	Physicia Medic		James Ross Si	c					Febru	ary 2	28, 20	12	10:18 AM
	Examin		4a. Facility Name (if not institutio	4b. City, Town,	or Location of D	Death	4c. County of Death						
مرسود			Elkton Care &			to a k to Salt ato A	E1kto		Um lan. (f			cil	
	Funeral Director		219-60-7769 1 X M 2 □ F 58 Yrs. Months							Day, Year)	9. Birthplace (State or Foreign Country) Mary Land		
	nd how at	٦	Usual Residence of Decedent 10a. State 10b. Count	у	10c. C	ity, Town or Lo	cation					10d	I. Inside City Limits
	laryla 3a-f s iffed	ect	MD	CEcil		E1kt	on						1 Yes 2 No
	or 28	قَ	10e. Street and Number	OLCII		ПТКС	10f. Zip Code			10g. C	itizen of Wh	at Country	n
	s23a nustb	Funeral Director	1 Price Drive	e				219	21		U	SA	
36	ge 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene. If frem 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at	þ	11. Marital Status 1 □ Never Married 2 □ Ma 3 □ Widowed 4 ☒ Divorce	Armed Fo	2 No		Was Decedent of If Yes, specify Cu 1 Yes 2 N		? (Specify Yes or Nuerto Rican, etc.)	0-	14. Race - Black, Specify:	White, etc	· ·
9	hours natur lical l	lete	15. Deced	ent's Education		16a. Dece	dent's Usual Occ			16b. l	b. Kind of Business Industry		
21215-0036	thin 72 ene. than "ı he Med	Completed	(Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) College (1-4 or 5+) painter						working	Τ.	ridges		,
d 2	led wi Hygie other ent, t	Be (17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surna									
ylan	ild be fi Mental iarked atic ev	၉	Walter Lawrence Ross Sr Edna Curry										
, Maryland	nd 2 shou salth and n 27 is m er traum		19a. Informant's Name/Relation: James Ross Jr			19b. Maili 175	ng Address (Stree Princip	io Road	r Rural Route Num. Port Dep	ber, City o	or Town, Stat , MD	te, <i>Zip Coo</i> 2190	de) 4
Baltimore,	permit. Page 1 and 2 sh Department of Health a Important: If item 27 is any injury or other tra		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation	n 3 ☐ Removal from	State	Place of Dispo cemetery, crea	osition (Name of matory or other p	lace)	Date	20c. l	Location - C	ity or Towr	n, State
Him	iit. Pa artmer artant njury		4 Donation 5 🛛 Other	-	ate At	lantic	Crem	3-	5-2012	G1e	en Bur	nie,	MD Funeral
Ba	Depa Impo any i	Ш	21. Signatur of Progral Service	Licens State	irecto	r Se	tate An	7099 R	dee RD	Hano	ver, K	D 21	Funeral
		Н	23a. Part 1. Inter the disease, o	or complications that	caused the dea							A	pproximate
	nysician/	ıı v	shock, o heart failure. List Immediate Cause (Final	-		1/10 01	E 50	1500					nterval Between Inset and Death
	Medical		disease or condition resulting in death)	a. Due to	(or as a consec	quence of):	>	وسروات	•15			_	
	Examiner	L	Sequentially list conditions,	h	Co	ALCA	R7 A	RTER	y DISE	EASE			
	p #	Examiner	if any, leading to immediate Due to (or as a consequence or).										
	executed an and rial-transit	xan	Cause (Disease or linjury that initiated events resulting in death) Last	c. Due to	(or as a consec	mence off:			_			_	
	be exician ician purial		resulting in death, East		(6) 45 4 551155	4401100 01/.							
09289	phys	edic		d									
Box 68	of the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. Within 24 hours after death this certificate has been signed by the attending physicia for the tuneral Director. After this certificate has been signed by the attending physicia completed filled in by the funeral director, page 2 should be detached for use as the bur	Completed by Physician/Medical	FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							23d. Date of Month			ay Year
P.O.	that the dea ned by the a detached f	y P							23e. Dio	23e. Did tobacco use contribute			cause of death?
S,	uires that n signed t ild be det	q þ							1	Yes 2	2 🗆 No 3	☐ Probab	oly 4 🗆 Unknown
oro	v require s been si should l	olete							24a. Wa		24b. We	re autopsy	y findings available
3ec	sician: The law is certificate has birector, page 2 s	mo:							pe 1 🗆 Ye	topsy rformed? s 2 X N	dea	ath? ☐ Yes 2	oletion of cause of
alF	rtifica	Be C	25. Was case referred to medica examiner?				26.	Place of Death (5 2 11	10 12	1 163 2	
<u>Ş</u>	Physic this ce ral direc	10	1 Yes 2 No	Hospital:	Inpatient 2	☐ ER/Outpatie	nt 3 🗆 DOA	ther: 4 Nursi	ng Home 5 🗆 Re	sidence	6 Other	(Specify)	
n of	ding Pl th. After th funeral		27. Manner of Death 1 Natural 5 Pend	ing .	of injury th, Day, Year)	28b. Time o injury	wo	ury at ork? □ Yes 2 □ No		e how inju	njury occurred		
Division of Vital Records,	to the Hospital or Attending Physician: The ki Within 24 hours after death. To the Funeral Director: After this certificate he completed filled in by the funeral director, page	Certificate:	Investigation Accident Investigation Suicide Could not be determined Jest Place of Injury - At home, farm, street, facto building, etc. (Specify)									oute Number,	
	ne Hospita n 24 hours ne Funeral pleted fillec	Medical	(Check 2 Medical	ng Physician: To the base Examiner: On the base g Nurse Practioner:	sis of examination	on and/or inves	tigation, in my opi	nion, death occur	rred at the time, date	e and plac	e, and due to	the cause	e(s) and manner stated.
× × × × × × × × × × × × × × × × × × ×								T .	ate signed (/				
D0065733							3	Feb	ruary	28,2	2012		
			30. Name and address of person	who completed cause			Print)	aH SMa	et Fri	دلم	, 70	219	121
	Sta Registr		31. Date filed (Month, Day, Year)	2012	Registrar's Sign	at b. A	ake			_			

Theresa Annette		- For Stata	te of Marylar		partment d <i>ertificate</i> d		and	Mental F		Reg. No.	201	2 0867
Physicia	n/	Registrar 1. Decedent's Name (First, Middle,		2.2					2. Date of De	ath Day	Year	3. Time of Death 0133 hrs
Medical Examin		Theresa A. Ross 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death							March 14		County of Dea	
		Harford Memorial				Havre o			lo pair ess		arford	irthulana (Stata as
Funeral Director		231-39-2340	5. Sex 7 1 M 2 X F		s. last birthday) 38	Months	1 Year Days	Hours Mi			1973 Fore	irthplace (State or ign VA ountry)
yas	F	Usual Residence of Decedent 10a. State 10b. County		10c. 0	City, Town or Loc	ation						10d. Inside City Limits
	_	MD Ceci	1		Risin	g Sun						1 Yes 2 No
with the Maryland ms 23a or 28a-f show be notified at once.	Director	10e. Street and Number 29 Mount St	reet			10f. Zip C	_{ode} 1911	·		10g. Citiz	en of What Co USA	untry?
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23s or 28s-f she injury or other traumatic event, the Medical Examiner must be notified at once	Funeral	11. Marital Status 1 Never Married 2 Mar	1 Yes		o If	Yes, specify	Cuban, N	flexican, Puen	Specify Yes or Note Rican, etc.)		White, etc.	erican Indian, Black,
s after rral", c	۵	3 Widowed 4 Divorced of Yes, Giva Year 1 Yes 2 X No specify: Specify: Whi 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/In										
10re, MD 21215-0036 sges I and 2 should be filed within 72 hours after nt of Health and Mental Hygiene. t: If item 27 is marked other than "natural", other traumatic event, the Medical Examiner	Completed	Elementary/Secondary (0-12) 6th	College (1-		during	most of workin	ng life. D	O NOT use re	etired)		nkno	
21215-0036 uld be filed within 7 Mental Hygiene. marked other than	Be	17. Father's Name (First, Middle, Last) Elsie Tussing 18.Mother's Name (First, Middle, Maiden Surname) Barbara Nickel										
D 21 should and Mer	٩	19a. Informant's Name/Relationsh Eric Ross	p (Type, Print) /son		179	ing Address 14 MO1			Rural Route N			te, Zip Code) ID 2122 2
and 2 sho lealth and item 27 is	H	20a. Method of Disposition			Ob. Place of Disp	osition (Name			Date		ocation - City	
MOFO Pages 1 ent of 1 nt: 1f		1 Burial 2 X Cremation 4 Donation 5 Other Spe		m State	crematory or d Bayviev	v Crem	ato	ry	3/20/1	2 I	Baltim	ore MD
Baltimore, permit. Pages I an Department of Hea Important: If iter		21. Signatur of uneral Service Mcerise 22. Name and Address of Facility 300 Mace Ave. Balto. MD										sex 21221
Physician		23a. Fart I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease a. Morphine and Oxycodone Intoxication Approximate Interval Between Onset and Death										
xaminer	ĺ	Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of):										
	اي	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):										
	mine	Counce Enter Underlying Course (Disease or injury that initiated										
nted d ansit		events resulting in death) Last Due to (or as a consequence or):										
iO, e be executed ysician and burial - transit	dical											
760 ficate b g physis	an/Me	IF FEMALE: 23b. Was decedent pregnant in the	23c. If yes, o			Fetal death	3	Ectopic preg	nancy	230	d. Date of delive Month	ery Day Year
Box 6876: death certificate the attending phy ed for use as the b	sicial	past 12 months? 1 Yes 2 No 9 V Unkr	4 Pregna	ant at time o	- L 4h	Other (Specif	fy)			1		
, P.O. Box 6876 res that the death certificate signed by the attending phy be detached for use as the U	Physicia	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contributing to death but not resulting in the underlying cause given in Part I.									use contribute	to the cause of death?
Division of Vital Records, P.O. halo ratending Physician: The law requires that the rafter death. al Director: After this certificate has been signed by led in by the funeral director, page 2 should be detach	Ď	Cardiomegaly							1 🗆 \	es 2	No 3 Pr	obably 4 V Unknown
ords, w requir	olete									opsy		autopsy findings available completion of cause of
Recol The law icate has	Completed								1 ✔ Ye	formed? s 2 N		
Vital Rec hysician: The laths certificate hall director, page	Be	25. Was case referred to medical examiner?	Hospital: 1 Ir	npatient 2	ER/Outpatie		_	f Death (Chec	sing Home 5	Reside	ence 6 Ott	ner:
ing Phy ing Phy After thi	n: To	27 Manner of Death 28a Date of Injury 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred								on		
Sion vitendii death. ctor: /	Certification:	1 Natural 5 Pending Investigation 2 Accident Pending Investigation 2 Replace of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rura								cations		
Divis Dopital or A hours after hours after y filled in b	rtifi		not be 28e. Place mined (Specify)		at nome, farm, si ad:Resid		office bu	iding, etc.	or Town Rising	State) 2	MD.	Rural Route Number, City St •
the Hospi hin 24 hour the Funcr	Medical Ce	29a. Certifier 1 Certifying Ph	ysician: To the best niner:On the basis o	t of my know of examinati	wledge, death oc	curred at the t	ime, date	and place, a death occurre	nd due to the ca	ause(s) ar	nd manner as st	ated. the cause(s)
To with	Me	29b. Signature and title of certifie	and manner st	ated.		29c.	License	number			- '	fonth, Day, Year)
		anetz					O.C.M	.E.		Mai	rch 14, 201	2
φ		30. Name and address of person Ana Rubio MD. Ass	who completed caus istant Medical E			altimore St	reet, B	saltimore, I	MD 21223			
St	ate	31. Date filed (Month, Day, Year)	32. Re	gistrar's S	gnature	1						

inthony Russo	Sta 1- For State Registrar	ite of Maryland i	Department of Certificate of Certifi		id Mental Hy	/giene Reg.	No. 201	2 0867			
Physician/	Decedent's Name (First, Middle	,Last)		-		Date of Death Month Death	Dav Year	3. Time of Death 1540 hrs			
Medical Examiner	ANTHONY F. RUSSO 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death										
e e e e e e e e e e e e e e e e e e e	4010 Silver Spring Roa			Nottingham			Baltimore Cou				
Funeral	5. Social Security Number	5. Sex 7. Age	e (In yrs, last birthday)	If Under 1 Yea		8. Date of Birth((MM/DD/YYYY) 9. Bir				
Director	212-46-5878	1_ X M 2_F	66 Yr	Months Day	rs Hours Min.	1-26-1	946	untry) MARYI ANI			
any.	Usual Residence of Decedent 10a. State 10b. County	· · · · · ·	10c. City, Town or Loca	ation		•	•	10d. Inside City Limits			
8	MD. BAL	ro.		NOTTINGHA	A.M.			1 Yes 2 No			
the Maryland or 28s-f sh tified at one Director	10e. Street and Number	10.	-	10f. Zip Code		10g	. Citizen of What Cou				
ith the Maryland 23s or 28s-f sho notified at once al Director	4010 SILVER SP	RING ROAD		212	236		USA				
r death with or items 23 must be no Funeral	11. Marital Status 1 Never Married 2 Mar	12. Was Decedent Armed Forces?	If		spanic Origin? (Sp n, Mexican, Puerto I		14. Race - Ameri White, etc.	ican Indian, Black,			
fter de l'. or ler mi	3 Widowed 4 ▼ Divo	roed If Yes, Give Year	□ No 54- 1970 ¹□	Yes 2 X No	specify:		Specify: WI	HITE			
ours aft atural" xamine	15. Decedent's Education (Speci		pleted) 16a. Decede		ition (Give kind of w		6b. Kind of Business/				
215-0036 be filed within 72 hours after death with the Maryland nital Hygione. rked other than "natural", or items 23a or 28a-f about, the Medical Examiner must be notified at once Be Completed by Furneral Director	Elementary/Secondary (0-12) 12TH	College (1-4 or 5	0+)		ANUFACTUE		UTO INDUST	TRY			
21215-0036 Juld be filed within 7 Mental Hygiene. Marked other than te event, the Medical TO Be Compile	17. Father's Name (First, Middle, I	_ast)	_		18.Mother's Name	(First, Middle, Ma	iden Surname)				
	ANTHONY RUSSO	-	1707 3130			D. LANGN					
O 4 5 5 5 1	19a. Informant's Name/Relationsh		1.5		et and Number or R EW CIRCLE		er, City or Town, State HILL, MD.				
e, MC and 2 sl leafth ar item 27 traums	ANTHONY J. RUSS 20a. Method of Disposition		20b. Place of Dispo	osition (Name of ce	metery.		20c. Location - City or				
Baltimore, MI permit Pages I and 2 a Department of Health a Important: If item 27 injury or other traum	1 Burial 2 XCremation	3 Removal from Sta	ATLANTIC	ther place) CREMATOR	¥ 3–19	-2012	GLEN BURN	E, MD.			
alti mit.] partm ports jury o	4 Donation 5 Other Specify: 21 Signature of Funeral Service Licensee 22. Name and Address of Facility CHIMUNEK FUNERALHOME I										
	Buan GU	lle		05 BELAI		NOTTINGE		1236			
Physician	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediete Cause (Final disease a. Hypertensive Atherosclerotic Cardiovascular Disease										
xaminer	Immediete Cause (Final disease or condition resulting in death)	a. Hypertensive At		diovascular Di	sease						
	Sequentially list conditions, b										
iner	if any, leading to immediate cause. Enter Underlying Cause	Due to (or as a conse	equence of):								
ted Insit Examiner	(Disease or injury that initiated events resulting in death) Last	Due to (or as a conse	equence of):				,				
ecuted and - transit		d			_						
SO, te be execut ysician and burial - tra	UNPENDED	AMENDED									
Box 68760, e death certificate be the attending physic; dor use as the burn hysician/Med	IF FEMALE: 23b. Was decedent pregnant in the	23c. If yes, outcom		etal death 3	Ectopic pregnar	ncy	23d. Date of deliver	/ Day Year			
). Box 687(the death certifica by the attending ph ched for use as the Physician/A	past 12 months?	novem '	time of death	Other (Specify)				•			
. Bo; he deat y the at hed for	Part II. Other significant condition	9 Unknown	n but not resulting in the	underlying on to	niven in Bort I	230 Did tobs	acco use contribute to	the cause of death?			
P. S that s that g	at ii. Outer agrifficant condition	one contributing to death	r but not resulting in the	underlying cause	given in raiti.		2 ✓ No 3 Prot				
Records, The law require ficate has been significate by completed Completed		- · · ·				24a. Was an		topsy findings available			
e law he has he has						autopsy perform 1 Yes 2	ed? death?	completion of cause of			
tal Rectain: The certificate ector, page	25. Was case referred to medical			26.Plac	e of Death (Check o		No 1 ✓ Ye	es 2 No			
Physician r this certi ral director	examiner? 1 ✓ Yes 2 No	Hospital: 1 Inpatie	nt 2 ER/Outpatie	nt 3 DOA	Other Nursing	g Home 5 Re	esidence 6 🗸 Other	r; Scene			
of ling Pl After funera	27. Manner of Death 1 ✓ Natural 5 ☐ Rendi	28a. Date of Inju (Month, Day,Y	ry 28b. Time of ear)			28d. Describe ho	w injury occurred				
Sior Mitend death ctor: yy the		tigation			Yes 2 No	00/ 1 1/ 10:					
Division of Vital Records, opital or Attending Physician: The law requiremental birectors: After this certificate has been sifilled in by the funeral director, page 2 should tecrtification: To Be Completed	deterr	not be	jury - At home, farm, str	eet, ractory, office	building, etc.	or Town, Star		aral Route Number, City			
Hospital Hospital Huncral ely filled	4 Homicide 29a. Certifier 1 Certifying Ph	ysician: To the best of m	y knowledge, death occ	urred at the time, d	late and place, and	due to the cause(s) and manner as stat	ed.			
To the Hospi within 24 hou To the Funct completely fil		niner: On the basis of exar	mination and/or investig	ation, in my opinio	n, death occurred at	t the time, date an	nd place, and due to th	e cause(s)			
T T S	29b Signature and title of certifier	1001	more	29c. Licen			29d. Date signed (Mo	nth, Day, Year)			
. (Out Vit	be feld		O.C.	.M.E.		March 16, 2012				
+1	30. Name and address of person Victor Weedn MD JD	who completed cause of d Assistant Medical		W. Baltimore S	Street, Baltimo	re, MD 21223					
State		32. Registra	Signature		,	, = = .220					
Registrar	MAK & U ZUIZ	Leave &	. parked								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death nine Physician/ March 17:02 PM usan elan 2 of 2 Medical give street a Town, or Location of Death **Examiner** 4c. County of Death 216-48-8998 217-46-2155 If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Min 1 🗆 M 2 💢 F **Director** 65 Sept. 9, 1946 MD 28a-f show 10a. State 10b. County at 10c. City, Town or Location 10d. Inside City Limits Director notified MD Carrol1 1 Yes 2 X No Westminster 10e. Street and Number 0 10f. Zip Code 10g. Citizen of What Country? must be Funeral 23a 3426 Nottingham Road 21157 USA items 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Examiner Black, White, etc. ō þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Page 1 and 2 should be filed within 72 hours after 1 Yes 2 X No Specify White Specify. "natural" Completed 3 XWidowed 4 Divorced Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. I other than " Elementary/Secondary (0-12) College (1-4 or 5+) the Dairy Farmer Agriculture event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Department of Health and Mental Important: If item 27 is marked o any injury or other traumatic eve ၉ Wilford Davis Aubrey Burke 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 548 Callander Way Abingdon, MD 21009 Mr. Matthew Rhine (Son) 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) cemetery, crematory or other place) View Cemetery 3/21/2012 Marriottsville, MD 22. Name and Address of Facility HAIGHT FUNERAL HOME & CHAPEL, PA 21. Signature of Funeral Service Licenses M00764 PO Box 195 Sykesville, MD 21784 23a. Part 1. Enter the disease, or complications hat caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Ph_sician Mucinous adenocarcinoma disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) attending physician and I for use as the burial-transif Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be twithin 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending the contract. P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) in the past 12 months?

1 Yes 2 No Month Day Year Pregnant at time of death signed by the at Id be detached fo Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ should be Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy perform 2 🗌 No 1 Yes Yes Division of Vital completely filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No ည 1 🗌 Yes 1 Npatient 2 ER/Outpatient 3 DOA Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c, Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred 5 \square Pending injury Accident Investigation 6 Could not be 3 Suicide 4 Homicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying wurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only Q 29b. Signa title of certifie 29c. License number 29d. Date signed (Month, Day, Year) RES-000 30. Name and address of person who completed cause of death (Item 23a) (Type. volte at Baltimore me Mesarwi mar 31. Date filed (Month, Day, Registrar's Signatur State Registrar

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 10:45A Walter March 13 2012 T. Shandrowsky Sr. Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death 9220 Ft. Smallwood Road Pasadena Anne Arundel 7. Age (In yrs. last birthday) Social Security Number 217–16–5872 If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign **Funeral** Hours **Director** 1 X M 2 🗆 F 91 Dec. 27 1920 MD Usual Residence of Decede 28a-f shov 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director notified 1 Yes 2X No Maryland Anne Arundel Pasadena 10e. Street and Numbe 10f. Zip Code ö 10g. Citizen of What Country? must be r Funeral 9220 Ft. Smallwood Road 21122 USA Page 1 and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Examiner Armed Forces?

1 XYes 2 No
If Yes, Give
Year or Dates. Black, White, etc. ò ģ 1 Never Married 2 Married 21215-0036 1 Yes 2 No Specify. Specify: "natural" Completed 3 Widowed 4 Divorced White Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) than I Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) the City of Baltimore Project Manager Be Baltimore, Maryland 17. Father's Name (First, Middle, Last) of Health and Mental H If item 27 is marked of Ir other traumatic even 18. Mother's Name (First, Middle, Maiden Surname) မ Alexander Szandrowski Mary Stelmach 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Helen M. Shandrowsky (spouse) Department of Health a Important: If item 27 is any injury or other trains 9220 Ft. Smallwood Road, Pasadena, MD 21122 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Marchate 19 1

 Burial 2 □ Cremation 3 □ Removal from State
4 □ Donation 5 □ Other (Specify) Glen Haven Cemetery 2012 Glen Burnie, MAryland ame and Address of Facility Stallings Funeral Home, 3111 Mountain Road, Pasadaena, MD 21122 21. Signatur 22. Name and Address of Facility 23a. Part 1. Enter the disease, or comshock, or heart failure. List only Interval Between Immediate Cause (Final Onset and Death Ph sician/ disease or condition Medical resulting in death) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause tuisease Due to (or as a consequence of): Exami nding physician and use as the burial-transit Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be to thours after death.
 Funeral Director: After this certificate has been signed by the attending physicia P.O. Box 68760 use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death been signed by the a should be detached s**ignificant conditions** contributing <u>t</u>o death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autops perforn 2 No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director, After this certific completely filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital Other: 1 🗌 Yes ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) Manner of Dea Certificate: 28b. Time of 28c. Injury at Natural 5 Pending work 1 Yes 2 No Accident Investigation Suicide 6 Could not be 4 Homicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier artifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check edical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Celtifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and ti

DHMH 17 Rev 06-2011

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Edmund Charles Storck, Sr 17,2012 March Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death n/a 7705 Wilson Avenue Baltimore Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, **Funeral** Months Days Hours Jan.11,1925 Maryland **Director** 219-12-5423 1 X M 2 □ F 87 Yrs 28a-f shov 10b. County items 23a or 28a-f sho ner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits **Funeral Director** MD n/a Baltimore 1 XYes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7705 Wilson Avenue 21234 USA Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Examiner Black, White, etc. 0 by 1 Never Married 2 Married 1 Yes 2 □ No If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. white "natural", Specify: Completed 3 ₩Widowed 4 Divorced Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Koppers Company Electrican permit. Page 1 and 2 should be filed with Department of Health and Mental Hygier Important: If item 27 is marked other to any injury or other traumatic event, the once. 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Mark Edmund Storck Rose Hedl 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3803 White Avenue-Baltimore, Maryland 21206 Paul Storck-son 20b. Place of Disposition (Name of cemetery, crematory or other place) Evans Funeral Chapel and 20a. Method of Disposition 20c. Location - City or Town, State ☐ Burial 2 😾 Cremation 3 ☐ Removal from State Mar.23,2012 Forest Hill, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Cremation Services 21. Signature of Funeral Service Licensee 22. Name and Address of Facili Evans Funeral Chapel and Cremation Services iondrie 8800 Harford Road-Parkville, Maryland 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ aran an disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner Due to (or as a consequence of Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) Be Completed by Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 1 Yes 2 □ No 3 □ Probably 4 □ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy performed? Yes 2 No 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital 2 No Other: Certificate: To 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1. Natural (Month, Day, Year) 5 Pending work? 1 Yes 2 No within 24 hours after death. To the Funeral Director: At completely filled in by the fu 2 Accident Investigation Suicide Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined

3×1

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Panayiotis Baltztzis, MD -8113 Harford Road, Suite 100-Parkville, MD 21234 32. Registrar's Signature

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

D 28949

29d. Date signed (Month, Day, Year)

19/12

31

DHMH 17 Rev 06-2011

State

Registrar

Medical

29a. Certifier

29b. Signature

(Check only one)

31. Date filed (Month,

MAR 20

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 11man Physician/ Million Medical 4a. Facility Name (if not institution, or Location of Death Examiner Randallstor nwes If Under 24 Hrs. If Under 1 Year 8. Date of Birth 9. Birthplace (State or Foreign Social Security Number 7. Age (In yrs. last birthday) **Funeral** Min (Month, Day, Year) 06/14/1952 1 X M 2 - F Maryland Yrs **Director** 217-58-6207 59 Usual Residence of Decedent 28a-f shov 10a. State 10b. County filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits notified at Director 1 X Yes 2 No MD Baltimore ō 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ms 23a or must be n Funeral U.S.A. 1912 Hillenwood Road 21239 ral", or items? 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. ģ 1 X Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Specify: "natural", Completed 3 Widowed 4 Divorced White er than 'natur, the Medical E 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Meone. life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 4 Photographer Photography Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Neuschaefer Robert Leroy Skillman, Jr. Katharine Mary 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Robert Skillman, Jr./ Father 1912 Hillenwood Road, Baltimore, MD 21239 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State Anatomy Gifts Registry 03/20/2012 Hanover, Maryland 4 ☑ Donation 5 ☐ Other (Specify) 21. Signature Juneral Service Licensee 22. Name and Address of Facility Anatomy Gifts Registry 7522 Connelley Dr., Ste. P, Hanover, MD 21076 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): DIVISION OT VITAL HECORDS, P.O. BOX 68760

the Hospital or Attending Physician: The law requires that the death certificate be executed the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): physician Physician/Medical Records, P.O. Box 68760 use as t IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☐ No for Pregnant at time of death signed by the a 9 Unknown q Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Were autopsy findings available 24a. Was an certificate has autopsy prior to completion of death? page 2- No 1 Yes 1 🗌 Yes Division of Vital 25. Was case referred to medical examiner? funeral director. æ Place of Death (Check only one) Hospital 1 Tyes 2 욘 1 Inpatient 2 ER/Outpatient 4 Nursing Home 5 Residence 6 Other (Specify) After this 27. Manner 28a. Date of injury 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred (Month, Day, Year) injury work?
1 Yes 2 No Natural 5 Pending within 24 hours after death.

To the Funeral Director: A completed filled in by the fu Accident Investigation 3 Suicide 4 Homicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. only one) 29b. Signature and title of certifier ne and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar 540

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar 08681 Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month March 2012 9:50 AM William Garland Scruggs 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Baltimore Towson Gilchrist Hospice Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) 8. Date of Birth Hours (Month, Day, Year) 216-42-2710 1 🖾 M 2 🗆 F Maryland 12/06/1943 68 Usual Residence of Decedent 10a. State 10b. County 10d. Inside City Limits 10c. City, Town or Location 1 🖾 Yes 2 🗌 No Baltimore 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? 21224 U.S.A. 214 S. Oldham Street 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, rmed Forces?

X Yes 2 \(\sum \) No Black, White, etc. 1 Never Married 2 X Married If Yes, Give Year or Dates. 1 ☐ Yes 2 X No Specify: Specify: 3 Widowed 4 Divorced White 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Transportation 12 Cab Driver 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) White William Scruggs Isabelle 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 214 S. Oldham Street, Baltimore, MD 21224 Carol Scruggs / Wife 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 M Donation 5 Other (Specify) 03/19/2012 Hanover, Maryland Anatomy Gifts Registry 21. Signature of neral Service Lica 22. Name and Address of Facility Anatomy Gitts Registry 7522 Connelley Dr., Ste. P, Hanover, MD 21076

Physician Medical **Examiner**

Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Me

Physician/

Medical

Director

Funeral

þ

Completed

Be

၉

MD

Examiner

Funeral

Director

"natural", or items 23a or 28a-f sho edical Examiner must be notified at

Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene.

Baltimore, Maryland 21215-0036

To the Hospital or Attending Physician: The law requires that the death certificate be executed

physician attending r ed by the a signed by t Id be detach cate has been sig , page 2 should b this certificate director, filled in by the funeral 24 hours after deal Funeral Director:

Division of Vital Records, P.O. Box 68760

23a. Part 1. Enter the disease or company shock, or heart failure. List only of	plications that caused the death. Do not enter the mode of dying, such as card ne cause on each-line.	iac or respiratory arrest,	Approximate Interval Between						
Immediate Cause (Final disease or condition resulting in death)	a Uschemie CArdio	mys pathy	Onset and Death Jeans						
resulting in death)	Due to (or as a consequence of):	0 1							
Sequentially list conditions, if any, leading to immediate cause. Enter Unidentyling Cause (Disease or injury	b. Due to (or as a consequence of):								
that initiated events resulting in death) Last	c. Due to (or as a consequence of): d.								
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (specify) 9 Unknown		Date of delivery Nonth Day Year						
	ontributing to death but not resulting in the underlying cause given in Part I.		ntribute to the cause of death?						
		24a. Was an 24b autopsy performed?	. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No						
25. Was case referred to medical examiner? 1 Yes 2 No	Hospital: 1	g Home 5 Residence 6	her (Specify Laspece						
27. Manner of Death 1 Natural 5 Pending 2 Accident Investigation	28a. Date of injury (Month, Day, Year) 28b. Time of injury 28c. Injury at work? 1 □ Yes 2 □ No	28d. Describe how injury occur	7						
3 ☐ Suicide 6 ☐ Could not b 4 ☐ Homicide determined	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Numi City or Town, State)	ber or Rural Route Number,						
(Check 2 Medical Exami	sician: To the best of my knowledge, death occurred at the time, date and plac iner: On the basis of examination and/or investigation, in my opinion, death occurre se Practitioner: To the best of my knowledge, death occurred at the time, date an	ed at the time, date and place, and d	ue to the cause(s) and manner stated.						
29b. Signature and title of certifier	Long Rely up 29c. License number	29d. Date signi	ed (Manth, Day, Year) Val 18, 2012						
30. Name and address of person who o	completed rause of death (Item 28a) (Type, Print)	ules St. B.	alto Md 2120						

Registrar

the within To the Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			1- For Amend Items 24a,25,26,27 per dr., g925,03/20/2012df Registrar Certificate of Death	Mental Hyg	iene eg. No. 2017	2 08682			
	Physicia	n/	1. Decedent's Name (First, Middle, Last)	Date of Deat Month	1.	3. Time of Death			
e en	Medic	al	Kimberly Constance Schofield 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death	MARCH	Day Year				
	Examin	er	4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death PENINSULA REGIONAL ARGICAL CINFU 344136414		4c. County of Dea				
7	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.	8. Date of Birth 9. Birthplace (State or I					
	Director		222-56-3446 1 \(\text{\text{\$M\$ in }} \) \(\text{\text{\$M\$ on ths}} \) \(\text{\text{\$Days}} \) \(\text{\$Hours} \) \(\text{\$M\$ in .} \)		Month, Day, Year) Country)				
	ind show at	or	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location	May 12,	1961	Delaware 10d. Inside City Limits			
	Maryla 8a-f tified	rect	MD Wicomico Salisbury			1 ☐ Yes 2 🔀 No			
	a or 2 be no	Ö	10e. Street and Number 10f. Zip Code	1	0g. Citizen of What C	ountry?			
	72 hours after death with the Maryland "matural", or items 23a or 28a-f sho fedical Examiner must be notified at	Funeral Director	304 Glen Ave; Apt FQ 21804		USA				
(0	or iter		11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Never Married 2 □ Married 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Yes 2 ☒ No	ecify Yes or No- Rican, etc.)	14. Race - Ame Black, Whit				
036	rs afte ral", Exan	Completed by	3 ☐ Widowed 4 🔀 Divorced 1 ☐ Yes 2 🔀 No Specify:		Specify: di	vorced			
5-0	2 hou "natu	plet	15. Decedent's Education 16a. Decedent's Usual Occupation (Specify only highest grade completed) (Give kind of work done during most of work)	ina I	16b. Kind of Business	/Industry			
121	within 7 giene. er than t, the M	Com	Elementary/Secondary (0-12) College (1-4 or 5+) Iffe. DO NOT use retired) 12 fast food worker		restaur	ant			
0	iled w Hygi other	Be	17. Father's Name (First, Middle, Last) 18. Mother's Name	e (First, Middle, N		dire			
ylar	should be filed n and Mental Hy 7 is marked oth raumatic event	T ₀	Leonard Verucci Constan	nce Alfo	rd				
, Mar			19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rura 304 Glen Ave Apt FQ	Route Number, Salisb	City or Town, State, Z ury, MD 21	804			
Baltimore, Maryland 21215-0036	permit. Page 1 and 2 Department of Healti Important: If item 2 any injury or other 1 once.		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City o	Town, State			
Balt	permit Depart Import any inj		21. Signal Firm ral to december 1 rector 22. Name and Address of Facility Sta	St; Bal	timore, MD	21201			
			23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac c shock, or heart failure. List only one cause on each line.	or respiratory arre	st,	Approximate Interval Between			
	Physician/ Medical	i n	Immediate Cause (Final disease or condition resulting in death) a. CIRRHOSIS OF LIVER			Onset and Death			
	Examiner		Due to (or as a consequence of):						
- X .		iner	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):						
	cuted ind transi	Examiner	Cause (Disease or injury that initiated events c.			,4.5.			
	cate be executed physician and s the burial-transit	dical E	resulting in death) Last Due to (or as a consequence of):			*			
2092	icate l phys s the	ledic	d						
89 ×	ending r use	an/N	FFEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy 1 □ Live Birth 2 □ Fetal death 3 □ Ectopic pregnancy		23d. Date of de	livery .			
P.O. Box 687	e death the att hed fo	Physician/Me	in the past 12 months? 1		Month	Day Year			
Ö.	hat the ed by detac	y Ph	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I	23e. Did tob	pacco use contribute to	the cause of death?			
S,	uires t n sign	Completed by	Diaseta Mellitus type Z Hypericosia	1 □ Y€	es 2 No 3 F	robably 4 🗆 Unknown			
Sorc	iw req is bee 2 shoi	plet	Hypericosian	24a. Was ar		ntopsy findings available			
Rec	ding Physician: The la h. Affer this certificate ha funeral director, page	Som		autops perform 1 \(\sum \) Yes 2	ned? death?	completion of cause of			
tal	cian: sertific ector,	Be	25. Was case referred to medical examiner? Hospital: 26. Place of Death (Check						
Ž	Physical chiral	12	1 Inpatient 2 TeSP/Outpatient 3 DOA Wirsing Ho		nce 6 Other (Spec	cify)			
Division of Vital Records,	nding tth. ; After e fune	cate	1 ▼ Natural 5 □ Pending (Month, Day, Year) injury work? 2 □ Accident Investigation M 1 □ Yes 2 □ No	28a. Describe no	w injury occurred				
/isic	r Atte	Certificate:	3 Suicide 6 Could not be		reet and Number or Ru	ıral Route Number,			
Ö	oital or urs aft ral Di			City or Town					
	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. Of the Funeral Director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Medical	29a. Certifier (Check only one) 1 ☑ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, are consistent only one) 1 ☑ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, are consistent only one) 2 ☑ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, are consistent only one)	the time, date and	d place, and due to the	cause(s) and manner stated.			
	To the comp	<	29b. Signature and title of certifier 29c. License number	25	9d. Date signed (Mont	h, Day, Year)			
			> Flan L MD. D0070129		3/12/20	0/2.			
			30. Name and address of person who completed cause of death (Item 23a) (Type, Print) IRFAN MOINUDDIN 1665 WOODBROOKE DRIVE, SA	LISBUR	y, MD 2	1804.			
	Stat Registra	e ar	31. Date filed (Month, Day, Year) NAR 2 0 2012 2. Registrar's Signature A. Janese						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1, Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Mar 14, 2012 Yea Physician/ 4:00a M Marthan S. Stokes Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner N/A **Baltimore** 1707 East Fairmount Avenue If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) **Funeral** (Month, Day, Year) Dec 14, 1946 Months Days Hours Min. Country) 1 M 2 X MD 65 Director 220-74-9465 Usual Residence of Decedent show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County Director 1 Yes 2 No **Baltimore Baltimore City** 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral U.S.A. 21231 1707 East Fairmount Avenue Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. 14 Race - American Indian Armed Forces? Black, White, etc. ģ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Black Completed 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) **Private Duty Nurse** Nursing Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည **Katie Mae Carr** Samuel Wright 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Baltimore, MD 21231 1707 East Fairmount Avenue. Robert Stokes, Jr. 20a Method of Disposition 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 KBurial 2 Cremation 3 Removal from State Mar 22, 2012 Owings Mills, Md. **Garrison Forest Veterans** 4 ☐ Donation _5 ☐ Other (Specify) 22. Name and Address of Facility
Estep Brothers Funeral Service, P. A.
1300 Eutaw Place Baltimore, Md 21217 Signature of Funeral Service Licensee 23a. Part 1. First the disease, or complications that caused to shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death death. Do not enter the mode of dying, such as cardiac or respiratory arrest Immediate Cause (Final Physician/ sever disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examine Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed and that initiated events resulting in death) Last Due to (or as a consequence of) nding physician Completed by Physician/Medical P.O. Box 68760 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Day Year Pregnant at time of death 5 Other (specify) been signed by the s should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? peritonitis 2 No 3 Probably 4 Unknown Division of Vital Records, 1 🗌 Yes 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy autope, performed 1 ☐ Yes 2 ☐ No Yes Be (25. Was case referred to medical examiner? funeral director, 26. Place of Death (Check only one) Hospital: 2 No 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 힏 1 Tes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred work? 5 Pending 2 🗌 No Accident Investigation after death Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide filled in by determined within 24 hours a To the Funeral I Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completed only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D0069314

State Registrar Name and address of person

31. Date filed (Month, Day, Year,

DHMH 17 Rev 7/2009

Waltham

Woods Pd Parterllie MD 21234

no completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

8813

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death I. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death SADOWSKI Physician/ ANTOINETTE Month Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Tate Hospice House Linthicum Anne Arundel Co. Social Security Number Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** (Month, Day, Year) Days Hours 216-05-5528 Director 1 □ M 2X F 93 06/13/1918 Baltimore, MD Usual Residence of Decede 10a. State 10b. County 10c, City, Town or Location 10d. Inside City Limits death with the Maryland Director notified 28a-f MD 1 Tes X No Anne Arundel Co. Glen Burnie 10e. Street and Numbe ŏ 10f. Zip Code 10g. Citizen of What Country? pe Funeral 23a must l 1817 Maltravers Road 21060 United States items Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 11. Marital Status 14. Race - American Indian, Armed Forces? 1 ☐ Yes 2 **X** No Black, White, etc. ö þ 1 Never Married 2 Married permit, Page 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or any injury or other traumatic event, the Medical Examin 1 Yes If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: Completed 3 X Widowed 4 Divorced White Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) yrs. Tailor Shop Seamstress Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) မ Rego Joseph Frances Ricchone 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mr. Ronald Sadowski / Son 148 Monroe Street, Unit 102 Rockville, MD 20850 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 03/21/2012 | Dundalk, Maryland Stanislaus Cem. 21. Signature of Funeral Service 22. Name and Address of Facility Singleton Funeral & Cremation M01121 Services PA; 1 2nd Ave SW; Glen Burnie, MD 21061 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Immediate Cause (Final Physician/ 191862797 disease or condition Medical resulting in death) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): Cause (Disease or injury that initiated events resulting in death) Last attending physician and for use as the burial-trans Due to (or as a consequence of): Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be to thours after death.

Funeral Director: After this certificate has been signed by the attending physicia Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown detached for Pregnant at time of death Month Day Year is certificate has been signed by the director, page 2 should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2 🗀 No ☐ Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: မ 1 \square Yes 2 - No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence within 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral of 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work?
1 Yes 2 No Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Dertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 3 only one)

State Registrar Name and address of person

31. Date filed (Month, Day, Year)

ARR 2 0 2012

MAR 20

DHMH 17 Rev 06-2011

completed cause of death (Item 23a) (Type, Print)

32. Registra

29c. License number

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 08685 1 - For Stete Registrer Certificate of Death Reg. No.-1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Year SHIPLEY LOVISE BLANCHE MARCH 2012 0247 16 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death HOSPITAL KERNAN BALTIMORE BALTIMORE CITY JAMES LAWRENCE If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Days 1 □ M 2 🗓 F Yrs. 214-22-0040 Feb 26, 1923 Pennsylvania Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 1 No Baltimore Reisterstown 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 225 Parkholme Circle 21136 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 TNo Specify: 3 ☑ Widowed 4 ☐ Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name /First, Middle, Maiden Surname: Arthur Emil Elvira Nicholls Peterson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Charles W. Shipley, Jr. Son 225 Parkholme Circle Reisterstown, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ⊠ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) Lake View Mem Park 3/20/12 Sykesville, Maryland 21. Signahue of Funeral Service Licens 22. Name and Address of Facility 11824 Reistertown Road J. Wayne Osterling | ELINE FUNERAL HOME Reisterstown, MD 23a. Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or head failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) CORONARY ARTERY DISEASE Due to (or as a consequence of): UNKNOWN DYSUPIDEMIA Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or injury that initiated events resulting in death) Last Due to (or as a consequence of): MELLITUS UNKNOWN DIABETES Due to (or as a consequence of): UNKNOWN HYPERTENSION IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 3 Ectopic pregnancy Month Year 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? PANCREXTIC CANCER 1 Yes 2 No 3 Probably 4 Unknown MALNUTRITION 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2 XNo 1 ☐ Yes 2XNo 1 Yes 26. Place of Death Check only one Hospital: 1X Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pendina investigation 1 Yes 2 No

Examiner anding physicien end use as the burial-transit The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760, sete has been signed by the page 2 should be detached or Attending Physician; efter death.

Diractor: Aft
in by the fur

Physician

/Medical

Examiner

Funeral

Director

s 23a or 28a-f show

other than "natural", or Items

nt of Health and Mental Hygie t: If Itsm 27 is marked other y or other treumatic avant, It

permit. Pages 1 and 2 should be filt Depertment of Health and Mental Hy Important: if Itam 27 is marked oth any linjury or other treumatic svent 2015s.

Physician

/Medical

Director

Funeral

Completed by

Be

၉

Physician/Medical Examiner

Be

Certification; To

Medicai

MD

with the Maryland

filed within 72 hours after death Hygiene.

Baltimore, Maryland 21215-0036

23b. Was decedent pregnant in the past 12 months? 9 Unknown

Completed by

25. Was case referred to medical examiner? 1 ☐ Yes 2 No

> 1 Natural 2 Accident 6 Could not be determined 3 ☐ Suicide 4 Homicide

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one) 15 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

29b. Signature and title of certifier

ATTENDING PHYSICIAN

D005212Z

29d. Date signed (Month, Day, Year) MARCH 16 2012

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ZZOO KERNAN DRIVE, BALTIMORE, MD ZIZO7 PETA-GAY JACKSON BOUTH, MD

State Registrar

31. Date filed (Month, Day, Year)

32. Registrar's Signature parker

DHMH 17 Rev 1/2001

To the Hospital o within 24 hours of To the Funerel D

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 🤈 🖺 State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Physician/ Month Day Thomas 03 2012 Arlene 6 1:30 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b City Town or Location of Death 4c. County of Death Baltimore 1140 Linden Ave Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 8. Date of Birth Days Hours (Month, Day, Year) **Director** 1 🗌 M 2 💢 F 212-58-4491 61 Yrs 01 14 51 MD Usual Residence of Decedent 28a-f show 10a. State must be notified at 10c. City, Town or Location 10d. Inside City Limits Directo Baltimore MD NA 1X Yes 2 No 10e. Street and Number ō 10f. Zip Code 10g. Citizen of What Country? Funeral 23a U.S.A. 21227 1140 Linden Ave filed within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) "natural", or iten edical Examiner 11. Marital Status Was Decedent Ever in U.S. 14. Race - American Indian, Armed Force \$ 1 X Never Married 2 Married 1 ☐ Yes 2 X No If Yes, Give Maryland 21215-0036 If Yes, Give Year or Dates. 1 Yes 2 No Specify: Completed 3 Widowed 4 Divorced Specify: Black er than "natur , the Medical B 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Good Sheppard 12th grade College (1-4 or 5+) Supervisor Staff Senior Center Ith and Mental Hygien 27 is marked other the traumatic event, the Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Sarah Thomas Jessie Thomas 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) nt of Health a t; If item 27 is or other trai 140 Linden Ave, Baltimore, Md 21227 Robin Smith-Daughter Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 ☐ Burial 2 🔀 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Important; It any injury or once. 3/20/2012 |Baltimore, Md On-Site 21. Signature of Juneral Service License 22. Name and Address of Eacility March F/H West al 4300 Wabash Ave, Baltimore, Md 21215 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Interval Between Immediate Cause (Final astatic Onset and Death breast Physician cancer disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to for as a consequence of Exami ig physician and as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): attending physician for use as the burial Physician/Medical Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Month Pregnant at time of death signed by the at Id be detached for P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 9 none 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Records, Completed 24a. Was an Were autopsy findings available prior to completion of cause of cate has page 2 s autonsv death? this certificate 1 ☐ Yes 2 ☐ No 2 No Division of Vital To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) 1 ☐ Yes 2 ☑ No 2 Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending injury work? 1 ☐ Yes 2 ☐ No Accident Investigation Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f, Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29d. Date signed (Month, Day, Year) 03/19/2012 D69268 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Robert S. Miller, MD; 10453 Falls Rd #415, Lutherville, MD 21093

Registrar
DHMH 17 Rev 06-2011

State

31. Date filed (Month, Day, Year)

MAR 2 0 2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 1 - For State Registrar State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 16, 2012 Marie Amanda Tyler March 2:15 A^{M} Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Baltimore Dulaney Valley Assisted Living Baldwin 8. Date of Birth
(Month, Day, Year)
July 2,1920 Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** 6. Sex 7. Age (In yrs. last birthday) Days 216-20-0108 Maryland Director 1 M 2 XF 91 Yrs Usual Residence of Decedent 28a-f show "natural", or items 23a or 28a-f sho 10a. State 10c. City, Town or Location 10d. Inside City Limits Director MD Baltimore Cockeysville 1 Yes 2 XNo 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Funeral 21030 11938 White Heather Road USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Completed by 2 XNo 1 Never Married 2 Married 1 Yes If Yes, Give 1 ☐ Yes 2 X No Specify: white 3 ₩ Widowed 4 □ Divorced Specify: Year or Dates Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Hutzlers Department Elementary/Secondary (0-12) College (1-4 or 5+) ald be filed within Mental Hygiene. other traumatic event, the Retail Store other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Louise Schramm Norton Cain 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 27 11938 White Heather Road-Cockeysville, Maryland Reverend George Weitzel, Jr-son item Important: If iten 20b. Place of Disposition (Name of cemetery, crematory or other place Moreland Memorial Park 20a. Method of Disposition 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Mar.19,2012 Parkville, Maryland 22. Name and Address of Facility
Evans Funeral Chapel and Cremation Services
8800 Harford Road-Parkville, Maryland 21234 . Signature of Funeral Service Licensee -cnarae 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on Immediate Cause (Final Onset and Death Physician/ disease or condition Medical resulting in death) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Cause (Disease of injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical the IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months?
1 Yes 2 No
9 Unknown Month Day Year Pregnant at time of death Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy death? this certificate 1 Tes Yes funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) 6 Sother (Specify) Hospital: 1 ☐ Yes 2 🗷 No Other: LIVING ၉ 4 Nursing Home 5 Residence 1 Inpatient 2 ER/Outpatient 3 IDOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 □ Yes 2 □ No 28d. Describe how injury occurred Certificate: or Attending 1 Natural 5 Pending iniury 2 Accident
3 Suicide Investigation Funeral Director: 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Hospital Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Tirtifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29d. Date signed (Month, Day, Year) Signature a 29c. License number ETCIANS +OS HICOEDE

DHMH 17 Rev 06-2011

Registrar

Maryland 21215-0036

Baltimore,

Box 68760

P.O.

Division of Vital Records,

Please Type or Print in Black Indelible Ink Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death March 18, 2012 Physician/ 6:05 A_M Mary Tapman Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore Stella Maris Timonium 8. Date of Birth (Month, Day, Ye If Under Social Security Number 6. Sex Year If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** Months Days Hours Min 219-16-6003 Director 89 Maryland 1 □ M 2 🔀 F Oct.21,1922 Yrs 28a-f show 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location notified at Director Baltimore Baltimore MD 1 Yes 2 X No 10e. Street and Number 10f. Zip Code ö 10g. Citizen of What Country? must be 21234 23a Funeral 8800 Old Harford Road USA items 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian. Armed Forces?

1 Yes 2 No Examiner Yes, specify Cuban, Mexican, Puerto Rican, etc. Black, White, etc. ö ģ 1 Never Married 2 Married Maryland 21215-0036 white If Yes, Give Year or Dates 1 ☐ Yes 2 ☐ No Specify: "natural", Completed 3 X Widowed 4 Divorced the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working 16b. Kind of Business/Industry filed within 72 al Hygiene. life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) At Home Homemaker 12 event. Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental F ည Gertrude Nickle Nickel Frank Martin traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
8810 Walther Blvd, Apt. 226-Parkville, Maryland 21234 Department of Health an Important: If item 27 is any injury or other tractonce. Frank Martin-brother altimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place)
Evans Funeral Chape!
and Cremation Ser. Belair 1 🗌 Burial 2 😾 Cremation 3 🗌 Removal from State Forest Hill, Maryland Mar. 20, 2012 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Licensee 22. Name and Address of Facility Evans Fineral Chamel and Chematicn Services 8800 Harford Road-Parkville, Maryland andre LTM 23a. Part 1. Enter the disease, or complications that caused the death. D not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ PST disease or condition Medical resulting in death) nsequence of): Examiner Sequentially list conditions, if any, leading to in redicte cause. Enter Underlying Examine Due to (or as a consequence of): attending physician and I for use as the burial-transit executed Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Year Month Day Pregnant at time of death 5 Other (specify) been signed by the a should be detached 9 Unknown P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records, Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy performed?

1 Yes 2 No this certificate 1 ☐ Yes 2 No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director; After this certifica 25. Was case referred to medical funeral director, 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital 2 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) Certificate: Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred injury 1 Natural 5 Pending Investigation filled in by the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completely Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 3 🗆 only one 29d. Date signed (Month, Day, Your) 29b. Signature and title of certifie 29c. License number 2012 av 0 Name and address of person who completed cause of death (Item 23a) (Type, Print) 0 TIMONIUM, MD 21093 ERNESTINE WRIGHT, 2300 DULANEY VALLEY ROAD M.D.32. Registrar's Signature State

Registrar

2012

19,

MARCH

TAPMAN

MARY

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			State of Maryland / Depa		Mental Hygie	ene	
			1109.01.01	tificate of Death		g. No. 2012	08689
	Physicia	n/	Decedent's Name (First, Middle, Last)		2. Date of Death Month	Day, Year	3. Time of Death
	Medic	al	Timothy Wayne Trout		March	15/2 2012	12 - 17 M
)	Examin	er	4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Death	on
	Funeral		12115 Big Pool Road 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	Clear Spring If Under 1 Year If Under 24 Hrs.	8. Date of Birth	Washingt 9. Birtho	OU slace (State or Foreign
	Director		214-36-8143 1 ☒ M 2 □ F 7rs.	Months Days Hours Min.	(Month, Day, Ye	(ear) Count	try)
_	, M		Usual Residence of Decedent /3		06/09/1		ryland
ryland	-fsh ieda	턍				[1	0d. Inside City Limits 1 Yes 2 No
M	r 28a notif	Pire	MD Washington Clear S	pring 10f. Zip Code	110	g. Citizen of What Coun	
ith tt	23a c st be	ral		21722		U.S.A.	uy:
ath v	ems r mu	Funeral Director	12115 Big Pool Road	Was Decedent of Hispanic Origin? (Spe	ecify Yes or No-	14. Race - America	an Indian,
6	or it	by F	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ No	f Yes, specify Cuban, Mexican, Puerto	Rican, etc.)	Black, White, e	etc.
15-0036 72 hours after death with the Maryland	ural"	Completed	3 ☐ Widowed 4 ☐ Divorced Year or Dates.	1 ☐ Yes 2 🛣 No Specify:		Specify: Whi	ite
15-6	"nat	ple	(Specify only highest grade completed) (Give I	dent's Usual Occupation kind of work done during most of work	ing 16	6b. Kind of Business/Ind	dustry
212 within	ene. r thar he M	ပ္ပ	Elementary/Secondary (0-12) College (1-4 or 5+)	O NOT use retired) borer		Heavy Mac	hines
2 S	Hygi other	Be	17. Father's Name (First, Middle, Last)		e (First, Middle, Mai		
land Pe filed	fenta	유	Clarence Leroy Trout	Grace	Eleanor	Carey	
lary	and Mentall r is marked c raumatic eve		19a. Informant's Name/Relationship (Type, Print)	ng Address (Street and Number or Run	al Route Number, Ci	ity or Town, State, Zip C	ode)
∑	Health tem 27			5 Big Pool Road,	Clear Spr	ring, MD 21	722
Baltimore, Maryland 21215-0036	If ite		20a. Method of Disposition 1	sition (Name of natory or other place)	Date 20	Oc. Location - City or To	wn, State
tim	tmen rtant: njury		4 🗷 Donation 5 🗆 Other (Specify) Anatomy G			Hanover, Ma	
Bal	popularies of the set and Mental Hygiene. Important If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.			Name and Address of Facility A 522 Connelley Dr.	•	ifts Regist	•
		Н	23a. Part 1. Enter the disease or complications that caused the death. Do not enter			170	Approximate
O.	n sician/		shock, or heart failure. List only one cause on each line. Immediate Cause (Final	2	, , ,		Interval Between Onset and Death
	Medical		disease or condition resulting in death) a. Due to (or as a consequence of):	rosts lines			41248
- Table 1	xaminer						
-		iner	Sequentially list conditions, if any, leading to immediate cause. Enter this arrying Due to (or as a consequence of):				
	nd transi	Examiner	Cause (Disease or injury that initiated events c.				
e exe	ohysician and the burial-transit	al E	resulting in death) Last Due to (or as a consequence of):				
760 ate b	physia the b	edical	d				
68 Sertific	attending ph	W/C	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy			23d. Date of delive	in/
OX eath c	after d for u	Physician/Me	in the past 12 months? 1 Live Birth 2 Li Fetal death 3 L Pregnant at time of death 5 L	Ectopic pregnancy Other (specify)			Day Year
C. B.	by the ached	hys	9 Unknown				
P. P.	been signed by the s should be detached	by P	Part II. Other significant conditions contributing to death but not resulting in the u	inderlying cause given in Part I.	23e. Did toba	cco use contribute to th	e cause of death?
ds, quire	en siç ould b	ted			1 🗆 Yes	2 No 3 Prob	pably 4 Unknown
Division of Vital Records, tal or Attending Physician: The law requires	has be je 2 sh	Completed			24a. Was an autopsy	/ prior to cor	psy findings available inpletion of cause of
He He	cate h	S			performe 1 \sum Yes 2	death?	2 🗆 No
ital ician	certificate irector, pag	m	25. Was case referred to medical examiner? 1 Yes 2 No Hospital: I progress 2 FB/Outperies	26. Place of Death (Chec.		<u> </u>	
F Ye	r this eral di	<u>ان</u>	27. Manner of Death 28a. Date of injury 28b. Time of	nt 3 🗆 DOA 4 🗀 Nursing Ho	ome 5 Residence 28d. Describe how	ce 6 Other (Specify)	
on C	ath. : Afte e fune	cate	1 Natural 5 Pending (Month, Day, Year) injury 2 Accident Investigation	work? M 1 🗆 Yes 2 🗆 No	204. 20001120 11011	mary occurred	
Sic	er deg ector by th	Certificate:	3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, stre	eet, factory, office		et and Number or Rural	Route Number,
Div talor	rs aft al Dir led in	Č	building, etc. (Specify)		City or Town, S	State)	
Division of Vital Records, P.O. Box 68760 To the Hospital or Attending Physician: The law requires that the death certificate be executed.	within 24 hours after death. To the Funeral Director: After this certificate ha completely filled in by the funeral director, page	Medical	29a. Certifier (Check 2 Medical Examiner: On the basis of examination and/or invest	tigation, in my opinion, death occurred a	t the time, date and p	place, and due to the cau	ise(s) and manner stated.
the	ithin 2 the l	M	only one) 3		ace, and due to the c		tated.
٦	≥ 50		Michael Meland Mel	0 4(6C)	290	3 · 15 · 1	
	d		30. Name and address of person who completed cause of death (Item 23a) (Type, P			- (3.1	
	W			Redical Com	1 Haice	whom M	D
	Stat	te	31. Date filed (Month, Day, Year) 32. Registrar's Signatures				
	Registra	ar	MAR 2 0 2012 Severe 5. Again				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Helen Lenore Trainis 19:41 M March Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Upper Chesapeake Medical Center Harford Air Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs. 8. Date of Birth . Social Security Number 7. Age (In yrs. last birthday) **Funeral** (Month, Day, Year) Days Hours **Director** 219-16-3925 1 🗆 M 2**X** F 85 10/16/1926 Maryland show 10d. Inside City Limits 10c. City, Town or Location ral", or items 23a or 28a-f sho Examiner must be notified at Director 1 Yes 2 No MD Harford Churchville 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Funeral 219 Olde Beau Ct. 21028 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Completed by 2 **X** No 1 Yes : 1 Yes 2 X No Specify. White Specify: 3 Widowed 4 Divorced Year or Dates traumatic event, the Medical 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) and Mental Hygiene. is marked other tha Treasury Clerk Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Baltimore, Maryland ျ John Joe Trainis Mary M. (Unknown) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau 219 Olde Beau Ct., Churchville, MD 21028 Mary Trainis (Kuntzman) - Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1

Burial 2

Cremation 3

Removal from State Atlantic Crematory 3/20/12 Glen Burnie, MD 4 Donation 5 Other (Specify) 22. Name and Address of Facility Schimunek Funeral Home of Bel Ait, 21. Signature of Funeral Service Licensee March 610 W. MacPhail Rd., Bel Air, MD 21014 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate
Interval Between
Onset and Death
2 hours Immediate Cause (Final Physician/ disease or condition Medical resulting in death) **Examiner** 0 Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events sician and burial-tran Due to (or as a consequence of): resulting in death) Last Physician/Medical P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown LENDRE 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months? Month Day Year 2 **N** No signed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Tes 2 No 3 Probably 4 Unknown Division of Vital Records, 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2 No 1 Tes Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No မ 14 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural injury work? 5 Pending 1 Yes Investigation 2 Accident To the Funeral Director: 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Hospital or Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier only one 29b. Signature and title of DO053568 hesapoaka 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) HOMPSONM.D 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar 3 DHMH 17 Rev 06-2011

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ March 19 ay 2012 Rosemary Ann Trianfo 0330 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Baltimore Timonium Stella Maris Hospice If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. . Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 215-54-1793 Months 01/01/1950 Director MĎ 1 🗆 M 2 🟋 62 Yrs. Usual Residence of Decedent 10c. City, Town or Location with the Maryland 10d. Inside City Limits Director ms 23a or 28a-f s must be notified White Marsh MD Baltimore 1 🙀 Yes 2 🗌 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21162 USA 11152 Red Lion Road items 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. "natural", or iter 14. Race - American Indian, ori Armed Forces Black, White, etc. Completed by Yes 2 No 1 Never Married 2 Married Maryland 21215-0036 If Yes. Give 1 ☐ Yes 2 🔀 No Specify: sWaj te 3 Nidowed 4 Divorced Year or Dates marked other than "natu matic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b, Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Packaging Plant Assembly Line Worker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mentai 2012 မ Helen Rolnick Important: If item 27 is marke any injury or other traumatic Joseph Ochlech 19a. Informant's Name/Relationship (Type, Print) and 2 sho Health and tem 27 is r 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) MARCH 19. 11152 Red Lion Rd White Marsh, MD 21162 Andre Trianfo-Son Baltimore, 20a, Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date Department of cemetery, crematory or other place) Burial 2 Donation Cremation 3 Removal from State 5 Other (Specify) Ardent Crematory 03.20.2012 Hanover, MD apre of ineral Service John L. Williams Funeral Directors, P.A. 4517 Park Heights Ave Baltimore, MD 21215 23a. Pa 1. Inter the disease, or complications that cause should, or heart failure. List only one cause on each line. The death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immedi Le Cause (Final disease or condition resulting in death) Onset and Death Physician/ LUNG CANCER Medical Due to (or as a consequence of): Examiner Sequentially list conditions. if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examin burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): ROSEMARY TRIONFO ed by the attending physician detached for use as the buria Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 5 Other (specify) Month Day Year Pregnant at time of death Yes 2 X No 9 Unknown 1 ☐ Yes 2 2 9 ☐ Unknown ate has been signed by page 2 should be detac Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Nnknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed after death.

Director: After this certificate 1 Yes 2 No Yes 2 X No Hospital or Attending Physician: director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 \square Nursing Home 5 \square Residence 6 X Other (Specify) **HOSPICE** Hospital: 2 X No မ 1 Inpatient 2 ER/Outpatient 3 DOA funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at work?
1 Yes 28d. Describe how injury occurred X Natural iniury 5 Pending 2 🗆 No the 2 Accider
3 Suicide Accident Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by determined 24 hours Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 X Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within. only one 29b. Signature an icense number 29d. Date signed (Month 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) TRACIE L. MORGAN, CRNP 2300 DULANEY VALLEY RD. TIMONIUM, MD 21093 31. Date filed (Month, Day, Year) NAR 2 0 2012 State

DHMH 17 Rev 06-2011

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Williams \mathbf{E} Physician/ Frank March 1^D7^y 2012^{ear} 2:06A Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death Arundel n, or Location of Death Pasadena Examiner Claiborne Road 320 8. Date of Birth 9. Birthplace (State or Foreign 6. Sex If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) Funeral Months Days Hours sept 10 217-50-8032 1947 Maryland 64 Director 1 🗙 M 2 🗒 F iral", or items 23a or 28a-f show Examiner must be notified at 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location Director Maryland Anne Arundel Pasadena 1 Yes 2 No 10f. Zip Code 21122 10e. Street and Number 305 Kramer Road 10g. Citizen of What Country? USA Funeral 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces? Black, White, etc. er than "natural", or the Medical Examin þ 1 Never Married 2 Married Maryland 21215-0036 white If Yes, Give Year or Dates 1 Yes 2X No Specify Specify 3 X Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry Je filed wn... *al Hygiene. *ar than "r (Give kind of work done during most of working life. DQ NOT use retired) Elementary (Secondary (0-12) College (1-4 or 5+) concrete construction worker permit. Page 1 and 2 should be filed within Department of Health and Mental Hygiene Important: If item 27 is marked other the any injury or other transmitted. Be 17. Father's Name (First, Middle, Last)

Joseph Edward 18. Mother's Name (First, Middle, Maiden Surname)

Bertha Nora Williams Copperthite 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 320 Claiborne Road Pasadena MD 21122 19a. Informant's Name/Relationship (Type, Print) Josephine Pritt Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal from State Metro Crematory Inc 3/20/2012 Baltimore Maryland 4 ☐ Donation 5 ☐ Other (Specify) Stallings Funeral Home P.A. 22. Name and Address of Facility 21. Signature of Funeral Service License 3111 Mountain Road Pasadena MD 21122 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complice shock, or heart failure. List only one s that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final Physician/ year disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) attending physician are for use as the burial-t Physician/Medical certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? or Attenting Physician: The law requires that the death Month Day Year Pregnant at time of death the i signed by t d be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 2 No 1 Yes 3 Probably 4 Unknown Completed should peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy page 2 within 24 hours after death.

To the Funeral Director, After this certificate 2 No 1 Yes 25. Was case referred to medical funeral director, 26. Place of Death (Check only one) Be examiner? Other: 4 - Nursing Home 5 - Residence 6 - Other (Specify) sister ည 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA Manner of Deat 28a. Date of injury (Month, Day, Year) 28b. Time of residence 28c. Injury at 28d. Describe how injury occurred Certificate: 5 Pending 1 Yes 2 No Accident Investigation filled in by the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined To the Hospital Medical certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier

Registrar

only one)

31. Date filed (Month, Day, Year)
MAR 2 0 2012

29b. Signat

and title of certifier

Name and address of person who completed cause of death (Item 23a) (Type, Print)

305 Hospital

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

D39505

Dr, Glan sumie,

2012

29c. License number

3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. Decedent's Name (First_Middle_Last) 2. Date of Death 3. Time of Death Physician/ Mont <u>Jerry Joseph Wyble</u> March 2012 5:00 PM Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 8600 Roaming Ridge Way Unit 307 Odenton Anne Arundel If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Min 385-30-2616 Director 1 XM 2 □ F 78 Yrs. Dec 24, 1933 Michigan show or 28a-f shov notified at 10a. State 10b. County with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No Maryland Anne Arundel Odenton 10e. Street and Number ŏ 10f. Zip Code ms 23a or must be n 10g, Citizen of What Country? Funeral 8600 Roaming Ridge Way Unit 307 21113 USA Page 1 and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces?
1 XYes 2 □ No 10 If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. þ 1955 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White "natural". Completed 3 Widowed 4 Divorced 1958 Year or Dates Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) ed other than 'event, the Me Elementary/Secondary (0-12) College (1-4 or 5+) d Mental Hygiene. marked other tha Electrical Engineer Westinghouse Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ of Health and Menta item 27 is marked other traumatic e Forest Marion Wvble Marjorie Lois Essick 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8600 Roaming Ridge Way Unit 307 Odenton, MD 21113 Mary Elizabeth Wyble, Wife 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State Department of H Important: If ite any injury or ott once. 1 ☐ Burial 2 XCremation 3 ☐ Removal from State cemetery, crematory or other place) 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory Inc. 03/19/12 Baltimore, Maryland Signature of Funeral Service Licensee Thomas Gregor 22. Name and Address of Facility Of Maryland, Inc. 299 Frederick Road Baltimore, Maryland 21228 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Leukemin Immediate Cause (Final Physician. TOG ress Ive nset and Death disease or condition Medical resulting in death) Due to (or as a con equence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of). Cause (Disease or injury that initiated events attending physician and for use as the burial-trans resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Month Day Year Pregnant at time of death been signed by the a should be detached f 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Hospital or Attending Physician: The law 24 hours after death.
 Funeral Director: After this certificate has be After this certificate has performe 1 ☐ Yes 2 ☐ No Yes 2 No 25. Was case referred to medica examiner? completely filled in by the funeral director, Be 26. Place of Death (Check only one) Hospital Other: ျှ 1 🗌 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 IDOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify 28a. Date of injury (Month, Day, Year) 27. Mann of Death 28b. Time of 28c. Injury at work? 1 □ Yes 2 □ No 28d. Describe how injury occurred Natural 5 Pending 2 Accident
3 Suicide
4 Homicide Investigation Μ 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the I within 2 To the I 3 🗆 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) ture and title of certifier 29d. Date signed (Month. Day, Year) 00043798 Mar 19 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Smil Sweet B novalas ordeans 1650 Baltimore Maryland 21287 State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Genevieve Elizabeth White Physician/ 2012^{Year} 6:00 P M March Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Manor Care Health Service Baltimore Towson Social Security Number If Under 24 Hrs. Year 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** Months Hours **Director** 445-20-9121 1 - M 2 X F 98 July 8, 1913 Pennsylvania Yrs 10b. County 10c. City, Town or Location 10d. Inside City Limits at Director ral", or items 23a or 28a-f s Examiner must be notified 1 Yes 2x No Maryland Harford Bel Air 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Funeral 23a 1807 Rollins Court 21014 United States 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married Yes 2X No Yes, Give Baltimore, Maryland 21215-0036 Page 1 and 2 should be filed within 72 hours after 1 Yes 2XXNo Specify Specify: White Completed 3 X Widowed 4 Divorced Year or Dates of Health and Mental Hygiene.
item 27 is marked other than "natur other traumatic event, the Medical 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Banking Clerk Retail Store Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) 2 Edward Mardis Rosella Morrison 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) James White / Son 1807 Rollins Court Bel Air, Maryland 21014 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Mar. 2012 Department of Important: If it any injury or o 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Evans Funeral Chapel 16, Forest Hill, Maryland Bel Air 22. Name and Address of Facility
Evans Funeral Chapel & Cremation Service-BelAir Funeral Service Licenses 21. Signatur, 3 Newport Drive Forest Hill, Maryland 21050 23a. Part 1. Enter the disease, or complication death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Onset and Death shock, or heart failure. List only one caus ement 4 Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, Physician/Medical Examiner Due to (or as a consequence of): if any, leading to immedicause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last To the Hospital or Attending Physician: The law requires that the death certificate be executed the burial-trans attending physician and for use as the burial-tran Due to (or as a consequence of): P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 month Month Day Year signed by the at d be detached for Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 perform 1 ☐ Yes 2 ☐ No 1 Yes 25. Was case referred to dical To Be 26. Place of Death Check only one) examiner? Other: 2 No 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA After this 27. Manne of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 Yes 2 🗌 No Accident Investigation Director: Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, filled in by 4 Homicide City or Town, State) 24 hours a Funeral C Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 Certifying Nyrse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated within 2 To the I 29b. Signature and title of ce 30. Name and address of perso eath (Item 23a) (Type, Print)

State Registrar 31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death Marrch 1. Decedent's Name (First, Middle, Last) 106 201-2 Physician/ 0255 Η. Weiner Joan Medical 4a. Facility Name (if not institution, give street and number)
Union Hospital 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Cecil Elkton Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Dav. 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days 1 D M 2 DX Months Hours March 15, 1932 212-32-9880 80 **Director** Usual Residence of Decedent or 28a-f show notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Elkton MD Cecil 1 Yes X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? o ed other than "natural", or items 23a or event, the Medical Examiner must be Funeral 21921 145 East HIgh Street death 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-11. Marital Status 14. Race - American Indian Yes, specify Cuban, Mexican, Puerto Rican. etc. Armed Forces?

1 Yes 2 No Black, White, etc. 1 Never Married 2 Married ģ within 72 hours after Baltimore, Maryland 21215-0036 White 1 Yes 2 No Specify: If Yes, Give Year or Dates 3 X Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) should be filed within 7 and Mental Hygiene.
7 is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Corman & Wasseman Seamstress 8th Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Fannie Buchannan Walter Huskins other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 st Department of Health a Important: If item 27 is any injury or other tra 20 Riverview Court Elkton MD Connie Odom /daughter 20a, Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Holly Hill Cemetery 3/20/12 Baltimore MD 4 Donation 5 Other (Specify) 21. Signal re Funeral Service Licensee 22. Name and Address of Facility 300 MAce Ave. Balto. MD Connelly Funeral Home of Essex 21221 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Coronace Immediate Cause (Final Ph_sician/ Unknown disease or condition resulting in death) Medical Due to (or as a constol ence of): Examine Sequentially list conditions Examine Due to for as a consequence of If any leading to immedicause. Enter Underlying Cause (Disease or iinjury that the death certificate be executed attending physician and for use as the burial-trans that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 5 Other (specify) 4 Pregnant Pregnant at time of death ed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
Rheuma loid Acthrelis signed to 23e. Did tobacco use contribute to the cause of death? <u>ک</u> 2 No 3 Probably 4 Unknown Completed page 2 should peen Kespiratory Failure 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Jas autopsy performed? within 24 hours after death.

To the Funeral Director: After this certificate I completed filled in by the funeral director, page 1 ☐ Yes 2 ☐ No Yes To the Hospital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 🗹 No 1 Inpatient 2 ER/Outpatient 3 DOA 2 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending injury work? 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 🛮 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check

State Registrar 31. Date filed (Month, Day, Year) **NAR 2 0 2012**

3

Jacken S MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29b. Signature and time of certifier

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

D0023322

Eleten MD21921

3.18.2012.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Jilli VVIIIOIG, SI.		- For State Criticate of Death	Reg.	No. 2012 186	9
Physician	_	Registrar 1. Decedent's Name (First, Middle,Last)	2. Date of Death	3. Time of Death	
ledical Examine		JOHN WILFORD, SR.	March 13, 2	012	
	4	4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death		4c. County of Death	
		5005 Conant Way Apt C Baltimore	To Date of District	(MM/DD/YYYY) 9. Birthplace (State or	_
Funeral Director		5. Social Security Number 6. Sex 1 Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 6. Sex 1 Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 6. Sex 1 Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 6. Sex 1 Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 6. Sex 1 Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 6. Sex 1 Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 6. Sex 1 Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 6. Sex 1 Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 6. Sex 1 Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 6. Sex 1 Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 6. Sex 1 Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 6. Sex 1 Age (In yrs. last birthday) If Under 2 If	12/26/	Eoreign	
\$u#		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location		10d. Inside City Lin	mits
A		MD BALTIMORE		1 X Yes 2	No
Maryland 28a-f show d at once.	ᅙ	Log The Oak	10g	. Citizen of What Country?	
hours after death with the Maryland natural", or items 23a or 28s-f sho Examiner must be notified at once	Director	10e. Street and Number 5005 CONANT WAY-APT C 21206 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Spa		USA.	
with ti			ecify Yes or No-	14. Race - American Indian, Black, White, etc.	
leath '	Funeral	1 Never Married 2 Married 1 Yes 2 No	Kicari, etc.)		
after o	ᆰ	3 Widowed 4 Divorced If Yes, Give Year 1 Yes 2 No specify: or Dates:	adi dian	Specify: BLACK	
nours Exam		15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of w during most of working life. DO NOT use retired to the complete of the compl	ed)		
2 2	Bet	Elementary/Secondary (0-12) College (1-4 or 5+) DRIVER	ļ	JOHN HOPKINS	
21215-0036 uld be filed within 72 hours after Mental Hygiene. marked other than "natural", even, the Medical Examiner	Completed	17. Father's Name (First, Middle, Last) 18.Mother's Name	(First, Middle, Ma	aiden Surname)	
	Be	LUTHER WILFORD MARY	LEE SI	AVAGE	
		10a Informant's Name/Relationship (Type Print) 19b, Mailing Address (Street and Number or R	tural Route Numb	er, City or Town, State, Zip Code)	
27 in an in a		DONALD WILFORD (SON) 32 MERCURY CT.	Date Date	20c. Location - City or Town, State	
	- 1		la III	RATINORE, M	D
MOFE Pages 1 tent of H int: If i	-	20a. Method of Disposition 1 Donaffon 5 Other Specify: 21. Signatur of Eureral Service Licensee 20. Place of Disposition (Name of Centerly) 22. Name and Address of Facility VA	21/12	BACITAGO	
Baltimore, permit. Pages 1 an Department of Hea Important: If iten injury or other tr	Ī	21. Signatur of Eureral Service Licensee 22. Name and Address of Facility	UGHN	GREENE FUNERHU	_
m 20 3 3	4	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or	r respiratory arres	st. shock, of heart Approximate Inte	erval
Physician		failure. List only one cause on each line			and
Examiner	1	Immediate Cause (Final disease or condition resulting in death) a. Hypertensive Atherosclerotic Cardiova Due to (or as a consequence of):	SCUIAL 1	Jisease	
	- 1	Sequentially list conditions, b			
	ē	if any, leading to immediate Due to (or as a consequence of): cause. Enter Underlying Cause			
2	Examine	Clisease or injury that initiated events resulting in death) Last Due to (or as a consequence of):			
ansit de Ox	ă	d			
ision of Vital Records, P.O. Box 68760, Attending Physician: The law requires that the death certificate be executed ar death. retor: After this certificate has been signed by the attending physician and by the funeral director, page 2 should be detached for use as the burial - transit	Medical	▼ UNPENDED			
760, cate bo	Ž	IF FEMALE: 23c. If yes, outcome of pregnancy		23d. Date of delivery Month Day Year	
687 certific ading	ian	23b. Was decedent pregnant in the past 12 months? 1 Live birth 2 Fetal death 3 Ectopic pregnant at time of death 5 Other (Specify)	incy	Month Day Year	
Sox leath e atter for u	Physician/	1 Yes 2 No 9 Unknown			
that the de need by the detached f		Part il. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.		pacco use contribute to the cause of death?	
P.(a P			2 No 3 Probably 4 V Unknow	
requi	Completed		24a. Was a autops	y prior to completion of cause	
e law te has ge 2 s	틹		perform 1 Yes 2		0
I Re		25. Was case referred to medical 26.Place of Death (Check			
Vita ysicia ysicia direct	To Be	examiner? 1 Ves 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other Nursir	-	Residence 6 Other: Scene	
of ag Ph		27. Manner of Death 28a. Date of Injury (Month Day Year) 28b. Time of Injury 28c. Injury at Work?	28d. Describe h	ow injury occurred	
ion tendii tor: /	atio	1 Natural 5 Pending 2 Accident Investigation		Dural Double Number	City
Division of Vital Records, P.O. Box 687 ral or Attending Physician: The law requires that the death certificar stafe death. 1a Director: After this certificate has been signed by the attending pled in by the funeral director, page 2 should be detached for use as the	tific	3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc.	28f. Location (S or Town, St	treet and Number or Rural Route Number, ate)	City
Spital Dours	Certification:	4 Homicide (Specify)	due to the course	o(e) and manner as stated	
Division of Vital Records, P.C. To the Hospital or Attending Physician: The law requires that within 24 hours after death. To the Funeral Director: After this certificate has been signed completely filled in by the funeral director, page 2 should be deta		29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and one) 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and one) 4 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and one)	at the time, date a	and place, and due to the cause(s)	
To the within To the comp	Medical	29b. Signature and title of certifier 29c. License number		29d. Date signed (Month, Day, Year)	
	-	O.C.M.E.		March 14, 2012	
—		30. Name and address of person who completed cause of death (Item 23a)			
0		Ana Rubio MD. Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, M	D 21223		
St	ate	31. Date filed (Month, Day, Year) 32. Registrar's Signature			
Regist					

DHMH 17 Rev 1/2001 OCME 2006 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		1	- State Amend Item 29	State of Mary d per dr.,	land / Dep 3 925,03/ Ce	artment of F 20/2012dh rtificate of L	tealth and I b Death	Mental Hyg	iene 201	2 08697
	Physicia		1. Decedent's Name (First, Middle, Last)		Walke			2. Date of Deat Month	h Day Year	3. Time of Death
ALC: N	Medic Examin		4a. Facility Name (if not institution, give st		MUINE		Location of Death	Febru	4c. County of Dea	
(See)			The Johns Hopk		pital	Batti		<u> </u>		
	Funeral Director		5. Social Security Number 6. Sex 219–32–6506 1 🖸	M ₂ □ _F	yrs. last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,	Year) Co	rthplace (State or Foreign ountry) unk
	nd te	_	Usual Residence of Decedent 10a, State 10b, County		74 c. City, Town or Lo	cation		Dec 8,	193/	10d. Inside City Limits
	farylar 3a-f sl	Director	MD		Baltim					1 √ Yes 2 □ No
	the N a or 28		10e. Street and Number			10f. Zip Code		1	0g. Citizen of What C	ountry?
	h with	Funeral	2938 E. Monument				205		USA	
980	1 and 2 should be filed within 72 hours after death with the Maryland f Health and Mental Hygiene. item 27 is marked other than "natural", or items 23a or 28a-f show item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	þ	11. Marital Status 1 □ Never Married 2 □ Married 3 □ Widowed 4 ☒ Divorced	 Was Decedent Ever i Armed Forces? □ Yes 2 □ No If Yes, Give Year or Dates. 	unk	Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 🏋 No	n, Mexican, Puerto	ecity Yes or No- Rican, etc.)	14. Race - Ame Black, Whit	
21215-0036	thin 72 hourne. than "nature Medical	Completed	15. Decedent's Edu (Specify only highest grad	College (1-4 or 5+)	(Give	dent's Usual Occup kind of work done o O NOT use retired)		unk	16b. Kind of Business	s/Industry unk
Maryland 2	should be filed within 7 h and Mental Hygiene. 7 is marked other than traumatic event, the M	To Be (unk unk 17. Father's Name (First, Middle, Last)	nk		unk	18. Mother's Nan	ne (First, Middle, N	faiden Surname)	unk
aryl	hould land Me s marl		19a. Informant's Name/Relationship (Typ	e, Print)	19b. Maili	ng Address (Street	and Number or Rui	al Route Number,	City or Town, State, Z	ip Code)
	e 1 and 2 s of Health of item 27 i		The Johns Hopkins			N. Wolf	e Street			287
Baltimore,	0		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ F 4 ☐ Donation 5 🔀 Other (Specify)	emoval from State	0b. Place of Dispo cemetery, cre	osition (Name of matory or other place	ce)	Date	20c. Location - City o	r Town, State
Ball	permit. Page Department of Important: If any injury or once.		21. Signate of Funeral Service Linens	de Direc	B	altimore,	MD 212	01	Baltimore	Street
	23a. Part Senter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of):									Approximate Interval Between Onset and Death
Special	Examiner	_	Sequentially list conditions	Due to (or as a cor	isequence on.					
-	sit d	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a cor	nsequence of):					
	ate be executed physician and the burial-transit	Exa	Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a cor	nsequence of):					
00	e be e iysiciai ne buri	edical								
68760	ertificat ding ph	/Mec	IF FEMALE:	c. If yes, outcome of pr	regnancy				204 5-464	
Box	he death ce y the attend iched for us	Physician/M	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	1 ☐ Live Birth 2 ☐ 4 ☐ Pregnant at tim 9 ☐ Unknown	Fetal death 3	Cther (specify)			23d. Date of de Month	Day Year
ds, P.O.	To the Hospital or Attending Physician: The law requires that the death certific within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending the completely filled in by the funeral director, page 2 should be detached for use as	þ	Part II. Other significant conditions con	tributing to death but no	ot resulting in the	underlying cause gi	ven in Part I.		oacco use contribute t es 2 No 3 F	o the cause of death? Probably 4 🗆 Unknown
Records,	The law rec ate has bee page 2 sho	Completed						24a. Was ar autops perforr 1 \(\sum \) Yes	med prior to death?	utopsy findings available completion of cause of es 2 No
ta	ician: certific rector,	Be	25. Was case referred to medical examiner? 1 Yes 2 No	ospital:		Oth	ace of Death (Chec			
of Vital	g Phys er this eral di	e: 10	27. Manner of Death	28a. Date of injury	2 ER/Outpatie	f 28c, Injur	4 ∐ Nursing H y at		ence 6 Other (Spe ow injury occurred	cify)
on (anding sath. or: Afte he fun	ficat	1 Natural 5 Pending 2 Accident Investigation	(Month, Day, Yea	ar) injury	M 1 🗆	(? Yes 2 □ No			
Division	tal or Attors after de al Directored in by t	al Certificate:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - building, etc. (Sp	At home, farm, st oecify)	reet, factory, office		28f. Location (St. City or Town	reet and Number or Ri n, State)	ural Route Number,
	the Hospi nin 24 hou the Funera npletely fill	Medical	(Check 2 Medical Examine only one) 3 Certifying Nurse	ian: To the best of my ler: On the basis of exami Practitioner: To the bes	nation and/or inves	stigation, in my opinie, death occurred at	on, death occurred the time, date and p	at the time, date an lace, and due to the	d place, and due to the e cause(s) and manner	cause(s) and manner stated. as stated.
	Vith Vith Com		29b. Signature and title of certifier PAP	4		Res			Pebruary 2!	
			30. Name and address of person who co	600 X	orth w	OIFE ST	reet P	altimo	re MD	21287
ı	Stat Registra		31. Date filed (Month, Day, Year) NAR 2 0 201	32 Registrar's S	Signature .	arker				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			For State		State of	Marylar	nd / Depa				and M	lental Hy	giene	001		0.0	C O O
			Registrar 1. Decedent's Name	(First Middle 1	act)		Cer	tificate (of De	eath		2. Date of De	Reg. No	0.2	2	1) 8	598
П	Physicia				so White							Month	Da		ear	3. Time 4:3(of Death
par to the	Medic Examin		4a. Facility Name (if r			er)		4b. City, Tov	wn, or L	ocation o	f Death	March		County of		7.5	<u>, b</u>
-			13206 Rab	bit Cha	se Road			Laure	1				Pi	rince	Geo	rge	
	Funeral		Social Security Nu		Sex 7. 1 X M 2 □ F	. Age (In yrs. I	* * * * * * * * * * * * * * * * * * * *	If Under 1 \ Months D		If Under 2	24 Hrs. Min.	8. Date of Bir	th	9	Birthpl Counti	nv)	or Foreign
	Director		577-78-38 Usual Residence of D	37	TAS MI Z L I	6	50 Yrs.					(Month, Da Jan . 18	,19	52		″Jama	iica_
	and show	ö		10b. County		10c. Cit	ty, Town or Lo	cation							10	d. Inside	City Limits
	Maryla 18a-f tiffiec	Director	MD	Prince (George	Laur	rel									TXXY	es 2 🗆 No
	a or 2	Ö	10e. Street and Num	ber	<u></u>			10f. Zip Co	ode				10g. Ci	itizen of Wha	at Count	ry?	
	h with	Funeral	13206 Ra	bbit Ch	-			2070	7				USZ	USA			
	72 hours after death with the Maryland n "natural", or items 23a or 28a-f show ledical Examiner must be notified at		 Marital Status Never Marrie 		12. Was Decede Armed Force	es?		Vas Decedent Yes, specify	t of Hisp Cuban,	oanic Orig Mexican	jin? (Spe , Puerto f	cify Yes or No- Rican, etc.)		14. Race - Black,	America White, e		
936	s after al", o Exam	d by	3 Widowed 4		1 Yes 2 If Yes, Give Year or Date		1	☐ Yes 2x	No	Specify:				Specify: E	Black	<	
0-10	hours natur Jical	lete	(0.000	15. Decedent's	Education		16a. Deced	lent's Usual O	ccupati	ion				Cind of Busir		_	
21215-0036	7 L 9	Completed	Elementary/Secon	, , , , , , , , , , , , , , , , , , , 	rade completed) College (1-4	or 5+)	(Give F life. Do	kind of work d O NOT use ret	lone dui tired)	ring most	of workir	ng				•	
2	iled within I Hygiene. other thar rent, the N	Be C	12				Assis	tant F						deral	Gove	ernme	nt
Maryland	ntal Hy ntal Hy ed oth event	To B	17. Father's Name (Fi)				- 1	18. Mothe Yola		(First, Middle,	Maiden	Surname)			
Ž	should be file n and Mental I 7 is marked o raumatic eve	ľ	19a. Informant's Nan		Type Print)		105 14-15-	- A dd (Cd			•	Route Numbe	0.4	· T Ol . 1	. 7: 0		
Ma	0 ± 2 ±		Verna C.	•			1					d, Laur		,	, ,	iae)	
re,	1 and of Heal item 2		20a. Method of Dispo	osition			Place of Dispo	sition (Name o	of	- :		ate		ocation - Ci		vn, State	
Baltimore,	permit. Page 1. Department of I Important: If it any injury or or		1 ☑ Burial 2 ☐ 4 ☐ Donation		☐ Removal from Si cify)	late	cemetery, cren o . Washi			i	Marc 201	h 23,	Ade	lphi,	MD		
alti	permit. Departr Importa any inju		21. Signature of Fund	eral Service Lice	nsee						Dona	aldson				P.A	
ш	20 2 2 3		J. Kens			1053						Laurel,		20707			
				failure. List only	nplications that cau one cause on each	used the deat line.	th. Do not ente			0	2.1		rest,			Approximately Be	etween
	Physician/ Medical	1	Immediate Cause (F disease or condition resulting in death)		a(ong	estive	hea	rt	fail	ure				_	Onset and	1 Death
Sandy.	Examiner		, , , , , , , , , , , , , , , , , , , ,		Due to (or	as a const qu	uence of):	hea arke		1							
		ner	Sequentially list con if any, leading to imr cause. Enter Underly	ditions, mediate	b. Due to (or	as a consequ	uence of:	arra	4	MIS	ea	10			1		
	d d	Exar iner	cause. Enter Underly Cause (Disease or iii that initiated events	ying njury	C		570		0						4		
	exec an ar irial-tr	Ě	resulting in death) La	ast	Due to (or	as a consequ	uence of):										
09	sate be execute physician and the burial-tran it	edical			d			····							+		
	artifica ding p	/Me	IF FEMALE:		23c. If yes, outco	me of progra	anou.										
Box 687	death certific he attending p ed for use as	Physician/M	23b. Was decedent p in the past 12 m	onths?	1 Live Bir	rth 2 🗌 Feta	al death 3 🗌							23d. Date of Month		y Day	Year
	g 9 9	hysi	1 Yes 2 U 9 Unknown	No	4 ☐ Pregnant at time of death 5 ☐ Other (specify) 9 ☐ Unknown												
P.O.	that t ned b e deta	by P	Part II. Other signific	cant conditions	contributing to dea	th but not res	sulting in the u	nderlying caus	se giver	n in Part I.		23e. Did t	obacco i	use contribu	te to the	cause of	death?
ds,	quires en sig uld b	pe										1 🗆	Yes 2	No 31	☐ Prob	ably 4 🗆	Unknown
Sor	aw rec as bee 2 sho	Completed										24a. Was auto		24b. Wer	e autop:	sy findings	s available
Re	The law cate has page 2 s	Con										perfo	rmed?	dea 0 1	th? Yes 2	·	
ta	iician: The certificate rector, pag	Be	25. Was case referred examiner?		Hospital:			2		e of Deatl	h (Check	only one)					
Ž	Physi this c	<u>2</u>	1 Yes 2 2 27. Manner of Death	No	1 In 28a. Date of		ER/Outpatien 28b. Time of		Other:			ne 5 🔀 Resi			Specify)		
n o	ding th. After fune	cate	1 X Natural 2 Accident	5 Pending	(Month,	Day, Year)	injury	- 1	Injury a work?	es 2 🗆	- 1	8d. Describe I	now injur	y occurred			
sio	Atten r dea ector: by the	Certificate:	3 Suicide 4 Homicide	6 Could not	be 28e. Place of		ome, farm, stre					28f. Location (Street an	d Number o	r Rural F	Route Nun	nber,
Division of Vital Records,	s afte		1 2 110111101110	acconning	building	, etc. (Specify	1)					City or Tov	vn, State)			
	To the Hospital or Attending Physician: The law requires that the within 24 hours after death. To the Funeral Director: After this certificate has been signed by the completed filled in by the funeral director, page 2 should be detach	Medical	29a. Certifier 13	XCertifying Ph	ysician: To the bes niner: On the basis	t of my know	ledge, death o	ccured at the	time, d	late and p	lace, and	d due to the ca	use(s) ar	nd manner a	s stated	elel and n	nanner etated
	the Phin 24	Me	only one) 3 L	Certifying Nu	rse Practioner: To	the best of m	y knowledge, d	eath occurred	at the t	ime, date	and place	e, and due to th	e cause(s	s) and manne	er as stat	ed.	iarinor stated.
	5 W W S		29b. Signature and ti	or cerumer					cense n		.0-	, I	29d. Da	ite signed (M	onth, D	ay, Year)	
			30. Name and addres	And powers who	completed asset	of dooth (harm	220) (5		DC	68	170)		3/19/1	12		
					12201 Plu	,	, , , , ,	,	ilv	er s	prin	g, MD :	2090	4			
	Stat	te	31. Date filed (Month,		1	iştrar's Signa	ture			5		3, 1,0 4	- 0 > 0				
	Registra	ar		ALD O A	2012		1 1	ald									

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 6 15 AM Physician/ 261 March Medical 4a. Facility Name (if not institution, give street and numb 4b. City, Town, or Location of Death 4c. County of Death **Examiner** County General Howard plumbia 170511 la If Under 1 Year If Under 24 Hrs. 8. Date of Birth Birthplace (State or Forcial Country) . Age (In yrs. **Funeral** (Month, Day, Months Hours Director 122-16-2556 1 M 2 X F 86 1925 May 27, New York Usual Residence of Deced 28a-f show 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location notified at Funeral Director 1X Yes 2 ☐ No North Tonawanda NY Niagara 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number must be 23a USA 699 Christiana Street death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Examiner Armed Force Black, White, etc. ö þ 1 Never Married 2 Married Yes 2 X No Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: If Yes, Give Specify: white "natural" Completed 3 Widowed 4 Divorced Year or Dates the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry nt of Health and Mental Hygiene.
t: If item 27 is marked other than Elementary/Secondary (0-12) College (1-4 or 5+) 12th <u>Telegraph Operator</u> Communications Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) မ Arthur Brockway Bertha Keyser 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 9142 Jan Ellen Rustin/Daughter Bryant Avenue, Laurel MD 20723 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2XXCremation 3 Removal from State Department of Important: If any injury or once. West Arundel Crem. 3/14/2012 4 ☐ Donation 5 ☐ Other (Specify) Odenton, MD Signature of Funeral Service Licenses 22. Name and Address of Facility Donaldson Funeral Home, P.A. M01103 313 Talbott Avenue, 23a. Part 1. Enter ne disease, or complications, shock, or leaf failure. List only one cause Immediate Cause (Final that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Onset and Death Marsine Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Cause (Disease or injury that initiated events resulting in death) Last To the Hospital or Attending Physician: The law requires that the death certificate be executed the burial-tran Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year Pregnant at time of death 5 Other (specify) 9 Unknow Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Ś 2 No 3 Probably 4 Unknown 1 Yes Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of certificate has b lirector, page 2 s autopsy performe 1 ☐ Yes 2 ☐ No 1 Yes 2 🗷 To Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 \(\text{Nursing Home} \) 5 \(\text{Residence} \) 6 \(\text{Other} \) Other (Specify) 1 Yes Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 27. Manner of Death 28d. Describe how injury occurred Certificate: within 24 hours after death.

To the Funeral Director: After t completely filled in by the funer. iniury work?
1 Yes 2 No Natural 5 \square Pending Investigation Accident Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, ☐ Homicide determined City or Town, State) Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie 1) 30641 30. Name and address of person who completed cause of death (Item 23a) (Type, Print Back Never need Road Belling 201-109

OHMH 17 Rev 06-2011

State

Registrar

31. Date filed (Month, Day, Year)

2

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 2012 Physician/ Doris Shores Wolff March 15, 7:30 P M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Montgomery Hospice Casey House Rockville Montgomery If Under 1 Year | If Under 24 Hrs Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) Social Security Number 7. Age (In vrs. last birthday **Funeral** Months 231-36-4477 80 Director 1 M 2 X F June 24, 1931 Virginia Usual Residence of Decedent 28a-f show 10d. Inside City Limits 10c. City, Town or Location aţ 10b. County Director Examiner must be notified 1 X Yes 2 □ No Maryland Rockville Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 0 807 Brice Road items 23a Funeral 20852 United States 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates. Black, White, etc. "natural", or 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 72 hours after 1 ☐ Yes 2 🛣 No Specify. White Completed 3 Widowed 4 Divorced the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) Own Home Homemaker Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) th and Mental H Lola Elizabeth Baber Roy Lewis Shores 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Page 1 and 2 st ment of Health a tant: If item 27 is John J. Wolff, Jr./Husband 807 Brice Road, Rockville, Maryland 20852 20a, Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State March 20, Gate of Heaven Cemetery 🛮 Burial 2 🗌 Cremation 3 🗌 Removal from State permit. Page Department or Important: If any injury or Silver Spring, Maryland 2012 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee Robert A. Pumphrey Funeral Home/Rockville, Inc M00198 300 West Montgomery Ave., Rockville, Maryland 20850 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Parkinson's Disease Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury Die-to Longs a consecuence offi Examir and as the burial-trar that initiated events Due to (or as a consequence of) resulting in death) Last attending physician Physician/Medical death certificate be Box 68760 IF FEMALE nse s 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant ☐ Ectopic pregnancy ☐ Other (specify) ____ in the past 12 months? Month Day Year Pregnant at time of death Yes 2X No 9 Unknown 9 Unknown P.O. or Attending Physician: The law requires that the signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown Division of Vital Records, Completed peen Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed? 1 ☐ Yes 2 🛣 No 1 🗌 Yes 2 🗆 No funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital 1 🗌 Yes 2 X No ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 L Other (Specify) 24 hours after death. Funeral Director: After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred Certificate: 28c. Injury at work?
1 Yes 2 No iniury X Natural 5 Pending Accident Investigation 6 Could not be Suicide Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Hospital Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 To the F only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) R143201 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar

31. Date filed (Month, Day, Year)

MAR 2 0 2012

Security S. Sarks

Debrah Miller, CRNP

6001 Muncaster Mill Road, Rockville, Maryland

20855

Registrar

DHMH 17 Rev 1/2001

State

30. Name and address of person

31. Date filed (Month, Day, Year)

MAR 2 0 2012

who completed cause of death

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 3. Time of Death 6:45 AM 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month March 18, Physician/ 2012 Vivian Tamassia Workman Medical 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) 4c. County of Death **Examiner** Gilchrist Center for Hospice Care Towson Baltimore If Under 1 Year 8. Date of Birth 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Hours Min. (May Day 6ear) 1928 Maryland 220-24-6539 **Director** 1 M 2 X or 28a-f show 10d. Inside City Limits 10a. State 10c. City, Town or Location must be notified at **Funeral Director** Baltimore Cockeysville 1 🗌 Yes 2 🗙 No 10f. Zip Code 10e. Street and Numbe 10g. Citizen of What Country? items 23a 21030 United States 300 International Dr. HC-132 be filed within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian traumatic event, the Medical Examiner Armed Forces?

1 Yes 2 No lf Yes, Give Year or Dates. Black White etc. 0 Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: White 'natural", 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) I Hygiene. other than " Elementary/Secondary (0-12) College (14 or 5+) Own Home Homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) d Mental marked o ပ္ Reiche Hugh Victor Tamassia Margaret permit. Page 1 and 2 should be Department of Health and Ment. Important: If item 27 is marked any injury or out. 19a. Informant's Name/Relationship (Type, Print) Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Diane Hall /Daughter 8223 Berryfield Dr. Nottingham, MD 21236 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Mar 19 I ☐ Burial 2 🕱 Cremation 3 ☐ Removal from State 2012 Beltsville, Maryland Chesapeake Crematory 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service 22. Cremation and FacilityFuneral Alternatives 8717 Green Pastures Drive Towson Maryland 21286 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, shock, or heart failure. List only one cause on each line Interval Between Onset and Death Immediate Cause (Final Ph_sician/ Strolce disease or condition resulting in death) early Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of): Cause (Disease or injury that initiated events resulting in death) Last and Due to (or as a consequence of): Physician/Medical The law requires that the death certificate be Box 68760 IF FEMALE: yes, outcome of pregnancy
Live Birth 2 Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 5 Other (specify) in the past 12 months?
1 Yes 2 No Pregnant at time of death Unknown 9 Unknown P.O. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Division of Vital Records. Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 1 Yes Yes Hospital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital 1 🗆 Yes Other 2 No မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 27. Manner of Death 28a. Date of injury 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) 1 Natural 5 Pending 1 Yes 2 No Accident Investigation s after death Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, filled in by 4 Homicide determined 24 hours Medical

State Registrar

within 2 To the I

29a, Certifier

(Check

only one) 29b. Signature

31. Date filed (Month, Day, Year)

6701

ress of person who completed cause of death (Item 234) (Type, Print)

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

MArch 18,2012

N. Charles St. Balto. and 2(20)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. AMEND ITEM#11perFH, G925, 3/3072012, WS State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ 2012 Clifford Whitmore, Jr. 11:53 A M March Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Montgomery Silver Spring 20 Woodmoor Dr. 8. Date of Birth (Month, Day, Year) If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Hours 217-44-0473 1 🕅 M 2 🗆 F 96 Director Nov. 17,1915 Yrs Massachusetts Usual Residence of Decedent 28a-f shov 10c. City, Town or Location 10d. Inside City Limits ms 23a or 28a-f shormust be notified at 10a. State 10b. County the Maryland Director Silver Spring MD Montgomery 1 XYes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20 Woodmoor Dr. 20901 United States of Health and Nental Hygiene.
If them 27 is marked other than "natural", or items or other traumatic event, the Medical Examiner mure other traumatic event, the Medical Examiner mure. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11 Marital Status 14. Race - American Indian Armed Forces?

1 Yes 2 X No Black, White, etc. 1 Never Married 2 Married ģ Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2X No Specify: White 3 Nidowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 5+ Federal Government Geologist Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Clifford Whitmore Marion Mason 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20 Woodmoor Dr., Silver Spring, MD 20901 Susan Hale Whitmore / Daughter Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date Department of F Important: If ite any injury or ot Page 1 cemetery, crematory or other place)
Chesapeake Crematory 1 Burial 2 X Cremation 3 Removal from State 03/20/2012 Beltsville, MD 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funoral Service Ligensee M00382 Rapp aramerafacand Cremation Services 933 Gist Ave., Silver Spring, MD 20910 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ GENERAL DEBILITY disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner ARTERIOSCLEROTIC CARDIOVASCULAR HAEART DISEASE ca quentiary list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of) attending physician and for use as the burial-transi Due to (or as a consequence of): Physician/Medical es, outcome of pregnancy
Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death detached the 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>6</u> should be 1 ☐ Yes 2X No 3 ☐ Probably 4 ☐ Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a, Was an cate has I ; page 2 s autopsy performed? 1 Yes 2 X No 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 \square Nursing Home 5 X Residence 6 \square Other (Specify) Hospital: To 1 🗌 Yes 2 🗶 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred 1 X Natural injury 5 Pending Investigation Accident 6 Could not be 3 Suicide
4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined

Hospital or Attending Physician: The law requires that the death certificate be Box 68760 P.O. Division of Vital Records, filled in by the funeral director, 24 hours after death Funeral Director: within 24 ho

To the Fune

completely f

Medical Examiner: On the basis of examination and/or investigation, in my oplinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Sign 29c. License number 29d. Date signed (Month, Day, Year, M.U. about H MARCH 19, 2012 D55522 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

🔼 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

1500 FOREST GLEN RD., SILVER SPRING, 20910 ROBERT H. GERARD M.D.,

31. Date filed (Month, Day, Year NAR 2 0 2012 State Registrar

29a. Certifier

(Check

Medical



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 17^{ay} March Karl H. Weaver 2012ª 6:40 P Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death Presbyterian Home Towson Baltimore 5. Social Security Number If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) April 9 1927 **Funeral** 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Country 235-36-1278 Director 1X M 2 D F 84 Ohio 28a-f show 10b County 10c. City, Town or Location with the Maryland 10d. Inside City Limits Funeral Director must be notified Maryland Baltimore Towson 1 Yes 2 X No 10e. Street and Number 5 10f. Zip Code 10g. Citizen of What Country? 23a 113 Versailles Circle 21204 U.S.A. permit. Page 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items any injury or other traumatic event, the Medical Examiner mu once. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces' Black White etc. þ 1 Never Married 2 X Married 1 Yes 2 □ No If Yes, Give Baltimore, Maryland 21215-0036 1 Yes 2 XNo Specify: Specify: White Completed 3 Divorced 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Physician medical Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, မ Karl B. Weaver Marion Hanna 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) LaVerne R. Weaver / Wife 113 Versailles Circle, Towson, Maryland 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) HilltopServiceCorp 4 Donation 5 Other (Specify) 3/20/2012 Towson, Maryland 21. Signature of Funeral 53 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. 1050 York Road Towson, Maryland 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate shock, or heart failure. List only one cause on each line Interval Between Onset and Death Immediate Cause (Final Ph_sician/ neumon, a disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) ng physician and as the burial-trans Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical the Hospital or Attending Physician: The law requires that the death certificate be in 24 hours after death.

the Funeral Director: After this certificate has been signed by the attending physicis Division of Vital Records, P.O. Box 68760 use 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 Fetal death
Pregnant at time of death 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ for in the past 12 months?
1 Yes 2 No Month 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by page 2 should be Althe mars 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☒ No 24a. Was an autopsy performed? the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 Tes 2 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural injury 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation 6 Could not be Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide determined Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Discretifying Physician: To the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 037016 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 6701 N. Charles St. Sc. te 4104 Salt-one Kennety M. Greene. MO 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar MAR 2 0 2012

X DHMH 17 Rev 06-2011

12-02105		Please Type or Print in Black Indelible			ible.						
Rachel Marie Ze	lde	State of Maryland / Department 1- For State Certificate		/giene	201	2 0870					
Physicia	an/	Registrar 1. Decedent's Name (First, Middle,Last)		Reg 2. Date of Death	. No.	3. Time of Death					
Medical Exami		Rachel Marie Zelder		Month March 13, 2	Day Year 2012	0336 hrs					
		4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of Death								
		515 Harbor Drive	Annapolis		Anne Arundel						
Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	If Under 1 Year If Under 24Hrs. Months Days Hours Min.	1	(MM/DD/YYYY) 9. Birtl Foreigr	1					
Director			Yrs.	Apr 17	, 1977 cou	intry) MD					
any		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Lo.	cation			10d. Inside City Limits					
*	L	MD Carroll	Sykesville			1 Yes 2 No					
Maryland 28a-f show d at once.	Director	10e. Street and Number	10f. Zip Code	10g	. Citizen of What Coun	21					
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho- injury or other traumantic event, the Medical Examiner must be notified at once.	Dire	1427 Woodridge Lane	21784		US	SA					
with ms 23	Funeral		Was Decedent of Hispanic Origin? (Spe		14. Race - Americ	an Indian, Black,					
death or ite	'n	1 Yes 2 No	If Yes, specify Cuban, Mexican, Puerto F	Rican, etc.)	White, etc.						
s after ral",	by	3 Widowed 4 Divorced If Yes, Give Yeer or Dates:	Yes 2 No specify:			nite					
hour natu	ted		dent's Usual Occupation (Give kind of wo most of working life. DO NOT use retire		6b. Kind of Business/In	dustry					
36 hin 7, than	ple		erinary Technician		V - +						
5-00 ed wit tygien of ther	Completed	17. Father's Name (First, Middle, Last)	18.Mother's Name ((First, Middle, Ma	Veterinar iden Surname)	<u>- y</u>					
21215-0036 suld be filed within 7 Mental Hygiene. marked other than ic event, the Medica	Be	ROnald N. Carlton	Brenda								
D 21 hould hould Me	မှ		ling Address (Street and Number or Ru			· _ ·					
MD and 2 sho alth and 27 is		Mr. Ronald N. Carlton (Father) 1427	Woodridge Lane Sy	kesville	e, MD 21784						
Baltimore, permit. Pages I ar Department of Hee Important: If ite		1 Burial 2 T Cremation 3 Removal from State crematory or	other place)		20c. Location - City or T	·					
ti Pag tment tment:		4 Donation 5 Other Specify: All Coun	ty Cremation 3/1	7/2012	Sykesville	e, MD					
Ball permit Depar Injury		21. Signature of Funeral Service Licensee 22 Sua X Hay M M00764	Name and Address of Facility HATG PO Box 195 Sykesvi	HT FUNE	RAL_HOME &	CHAPEL, PA					
Physician	Н	23a. Part I. Enter the disease, or complications that caused the death. Do not enter	10 DON 199 Dykesvi	itte, m	21/04	Approximate Interval					
/Medical		failure. List only one cause on each line. Immediate Cause (Final disease a. Shotgun Wound of He	ad			Between Onset and Death					
Examiner		or condition resulting in death) Due to (or as a consequence of):		-							
		Sequentially list conditions, b.		_							
	nine	if any, leading to immediate Due to (or as a consequence of): cause. Enter Underlying Cause C.									
Sit sd	Examiner	(Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):									
executed an and al - transit	g	d.									
	edic		7,65-1								
876 tificat ng ph	Š	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregnancy 1 Live birth 2	Fetal death 3 Ectopic pregnance	су	23d. Date of delivery Month Da	y Year					
Box 68760, e death certificate be the attending physic of for use as the burned for use	<u>Ş</u>	4 Pregnant at time of death 5	Other (Specify)								
. Bo. the deat y the at thed for	Physician/Medi	Part II. Other significant conditions contributing to death but not resulting in the	a underbine enues sives in Dest I	22a Did taha	cco use contribute to the	o cours of doubts?					
on of Vital Records, P.O. Box 68760, anding Physician: The law requires that the death certificate be ath. Tr. After this certificate has been signed by the attending physici he funeral director, page 2 should be detached for use as the buril	à	Contributing to death but not resulting in the	s underlying cause given in Parci.		2 ✓ No 3 Proba						
cords, F aw requires nas been sign 2 should be	Completed			24a. Was an		psy findings available					
COF law r has b	힏			autopsy performe	prior to co death?	mpletion of cause of					
tal Rec		25. Was case referred to medical	OO Plane of Death (Ohealase	1 ✓ Yes 2	No 1 Yes	2 No					
Division of Vital Records, talor Attending Physician: The law requirers after death. al Director: After this certificate has been sited in by the funeral director, page 2 should be	Be	examiner? Hospital: 4 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	26.Place of Death (Check or ent 3 DOA Other Nursing		sidence 6 🗸 Other:	Scene					
of V g Phy	<u>:</u>	27. Manner of Death 28a. Date of Injury 28b. Time of		28d. Describe hov	-						
ion of tending Pheath.	흲	1 Natural 5 Pending Fd 3-13-12 fd 03	30 am 1 Yes 2 🛣 No	unknown							
or Att after de Directe	ij	2 Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, str		28f. Location (Stre	et and Number or Rura	Route Number, City					
Div spital o hours aft meral Di	Certification:	4 Homicide determined (Specify) Found: Resid	ence A	nnapoli:	e)515 Harbor s,MD.	Dr.					
Divi To the Hospital or within 24 hours afte To the Funeral Dir completely filled in	- 1	29a. Certifier (Check only) Certifying Physician: To the best of my knowledge, death occ									
To th within To th	Medical	one) 2 Medical Examiner: On the basis of examination and/or investigand manner stated. 29b. Signature and title of certifier									
	~	250. Signalure and the or centrel	29c. License number O.C.M.E.	i	9d. Date signed <i>(Monti</i> March 14, 2012	n, µay, Year)					
VO		Wex	U,U.IVI.L.		viai∪ii 14, ∠UIZ						
Devol	l	 Name and address of person who completed cause of death (Item 23a) Ana Rubio MD. Assistant Medical Examiner 900 W. Ba 	Itimore Street, Baltimore, MD	21223							
Sta	ate	31. Date filed (Month, Day, Year) 2. Registrar's Signature									
Regist	_	MAR 2 0 2012 Runa B. Sans									

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Merroh Zito Ross Samuel Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Baltimore Washington Medical Center Glen Burnie 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth **Funeral Director** 215-28-1655 1 X M 2 □ F 80 MD 06/10/1931 or 28a-f show notified at 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits Director 1 Yes 2 X No MD Anne Arundel Severn ō 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ral", or items 23a or Examiner must be Funeral 21144 U.S.A. 844 Reece Road Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces Black, White, etc. þ 1 Never Married 2 Married 1 X Yes 2 ☐ No If Yes, Give Year or Dates. Maryland 21215-0036 han "natural", o Medical Exan 1 ☐ Yes 2 X No Specify 3 ₩ Widowed 4 Divorced Specify: Completed White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) the 12 Manager Westinghouse Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) should be file and Mental I is marked or ၉ Giantforte Zito Frances Rosario traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau 3 Stone Spring Court 21228 Catonsville, MD Mrs. Donna McGuire / Daughter Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 🛮 Burial 2 🗆 Cremation 3 🗀 Removal from State Glen Haven Mem. Park 03/19/2012 Glen Burnie, MD 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Lic 22. Name and Address of Facility 1 2nd Avenue SW Glen Burnie, MD MO1479 Singleton Funeral & Cremation Services, PA 23a. Part 1. Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each line. death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Interval Between Onset and Death Immediate Cause (Final h, sician/ disease or condition resulting in death) Medical to (or as a Certaliame Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to Exam executed and that initiated events burial-tra Due to lor as a consequence of resulting in death) Last Physician/Medical Box 68760 attending phys IF FFMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant Live Birth 2 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Day Pregnant at time of death 2 No g Unknown 9 Unknown P.O. I signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 Yes 2 □ No 3 □ Probably 4 □ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy perforn certificate 2X No Yes To the Hospital or Attending Physician; 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital 1 Yes Other: ၉ Inpatient 2 ER/Outpatient 3 DOA 4 \square Nursing Home 5 \square Residence 6 \square Other (Specify) funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending injury I hours after death.
uneral Director: Aftely filled in by the ful 1 Yes 2 No Accident Investigation 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 - Homicide determined City or Town, State) within 24 hours a

To the Funeral C

completely filled Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date'signed (Mon h, Day, Year) D4800b who completed cause of death (Item 23a) (Type, Print) 3017 DWUSH

DHMH 17 Rev 06-2011

State Registrar 31. Date filed (Month, Day,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 17 y 2012 March 8:50 A M Bertha Elizabeth Zealor Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore Gilchrist Towson Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Hours Director 217-20-8648 1 □ M 2**X** F 82 83 March 12 1929 Maryland or 28a-f show should be filed within 72 hours after death with the Maryland and Mental Hygiene.
' is marked other than "natural", or items 23a or 28a-f shov permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10b. County 10c. City, Town or Location Director 1 Yes 2X No Maryland Baltimore Parkville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral U.S.A. 21234 3108 Garden Avenue Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S Armed Forces? 14. Race - American Indian, 1 Never Married 2 Married Completed by 2 X No Baltimore, Maryland 21215-0036 1 Yes 2 X No Specify: Specify: White 3

✓ Widowed 4 □ Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Own Home Homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Virginia B. Schooler George W. Brewer 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ramona Beth Zealor / Daughter 3108 Garden Avenue, Parkville, Maryland 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State MorelandMemorialPark 3/23/2012 Parkville, Maryland 4 Donation 5 Other (Specify) Signature of Fun or Service Lives 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. 1050 York Road Towson, Maryland 23a. Part 1. Enter the disease, or comp eations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between
Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final colo-vecto concer metastatic Ph_sician/ disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Exami that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Be Completed by Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Dav Pregnant at time of death 5 Other (specify) 9 Unknown g Unknown Parkl. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 \sum Nursing Home 5 \sum Residence 1 ☐ Yes 2 ☐ No spece မ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) Manner of Death 28c. Injury at work?
1 Yes 2 No 28b. Time of 28d. Describe how injury occurred Certificate: After injury 1 Natural 5 Pending Accident
Suicide Investigation 24 hours after deatl Funeral Director: 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 To the F only one 29d. Date signed (Month, Day, Year)

March 17, 2012 29b. Signature at 2057 C nd address of person who completed cause of death (Nem 23a) (Type, Print)
A-R. Ley CBM (1670) N. Churles St. Balto. Md 2120/2 6701 State Registrar

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Justin Tyler Akers State of Maryland / Department of Health and Mental Hygiene 2012 08708 1- For State Certificate of Death Reg. No Registrar 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle,Last) Physician/ Month Day March 11, 2012 Medical Examiner 0806 hrs Justin Tyler Akers 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Cecil 1653 Frenchtown Road Perryville 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or **Funeral** Months Days Director Hours 212-27-2521 1^X M 2 F 25 April 27,1986 Country)Maryland Yrs Usual Residence of Decedent E I 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits is 23a or 28a-f show 1 Yes 2 X No 28a-f show Maryland Cecil Perryville with the Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1653 Frenchtown Road 21903 U.S.A. Funera 13. Was Decedent of Hispanic Origin? (Specify Yes or No-12. Was Decedent Ever in U.S. 14. Race - American Indian, Black, If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Armed Forces 1 X Never Married 2 Married 1 Yes 3 Widowed White 4 Divorced If Yes, Give Year Yes 2 X No specify: ğ Pages 1 and 2 should be filed within 72 hours, ment of Health and Mental Hygiene.

Tant: If item 27 is marked other than "naturior or other traumatic event, the Medical Exami 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Baltimore, MD 21215-0036 Eight Years never employed never employed 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) Richard Akers Debra Sue Payne 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Richard W. Akers (father) 165 Sassafras Street, Millington, MD 20b. Place of Disposition (Name of cemetery, 20a. Method of Disposition 20c. Location - City or Town, State Date crematory or other place) 1 X Burial 2 Cremation 3 Removal from State Principio Cemetery 03/16/12 Perryville, Maryland 4 Donation 5 Other Specify ²²Name and Address of Facility Lee A. Patterson & Son Funeral Home, P.A. Perryville, Maryland 21903-0766 21. Signature of Funeral Service Licenses Allterson 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval Physician Between Onset and /Medical Death Oxymorphone Intoxication Immediate Cause (Final disease zaminerگ or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions. Due to (or as a consequence of): Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last The law requires that the death certificate be executed Physician/Medical AMENDED 23a, 27, 28a-f, per me, g925 3-21-12 sm X UNPENDED attending physician or use as the bucial -Box 68760, IF FEMALE 23c. If yes, outcome of pregnancy 23d Date of delivery 23b. Was decedent pregnant in the Day 3 Ectopic pregnancy Month Yea 2 Fetal death past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? o ğ Records, P. 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of death? has performed? s certificate la rector, page ✓ Yes 2 No 1 🗸 Yes 25. Was case referred to medical 26.Place of Death (Check only one) Division of Vital Be examiner? Hospital: 1 Inpatient 2 ER/Outpatient 3 Other 4 Nursing Home 5 Residence 6 🗹 Other: Scene this 1 Yes After the 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification 1 Natural unknown 1 Yes 2 X No Pending fd 3-11-12 fd 8:00 am 2 Accident Investigation 28f. Location (Street and Number or Rural Route Number, City or Town, State) 1653 Frenchtown Rd. 28e. Place of Injury - At home, farm, street, factory, office building, etc 3 Suicide 6 X Could not be 4 Homicide Found in Residence Perryville,MD.

Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: A completely filled in by the fu within 2

29b. Signature and title of certifier 29c. License number arol Hallan

and manner stated

30. Name and address of person who completed cause of death (Item 23a)

31. Date filed (Months Day Year)

Carol Allan, MD Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223

State Registrar

Medical

29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

O.C.M.E.

29d. Date signed (Month, Day, Year)

March 12, 2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 3 LCAMO NTHONY Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Anne Arundel Anne Arundel Medical Center Annapolis 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year, Birthplace (State or Foreign Country) **Funeral** 7. Age (In yrs. last birthday) Days Hours Director 219-18-6251 1 **X** M 2 □ F 2/14/1923 Maryland 28a-f show 10a. State 10b. County 10c. City, Town or Location must be notified at Director Maryland Anne Arundel Edgewater 10e. Street and Number 10f. Zip Code ò 10g. Citizen of What Country? 23a Funeral 1 Strachan Place 21037 USA "natural", or items 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?
1 X Yes 2 □ No WWII Completed by 1 Never Married 2 Married Yes Yes, Give Baltimore, Maryland 21215-0036 Specify: White 1 ☐ Yes 2 X No Specify: 3 ▼ Widowed 4 □ Divorced Year or Dates other traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) than " should be filed within 7 and Mental Hygiene.
7 is marked other than Elementary/Secondary (0-12) College (1-4 or 5+) Industrial Engineer Canning Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Vincenzo A1camo Pietra Colianni 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1 and 2 si if Health in tem 27 i Linda Genna/Daughter 1 Strachan Place, Edgewater, MD 21037 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 🕅 Burial 2 🗆 Cremation 3 🗆 Removal from State Veterans Cemetery 3/7/2012 4 Donation 5 Other (Specify) Crownsville, MD 22. Name and Address of Facility George P. Kalas Funeral Home 21. Signature of Funeral Service License alas 2973 Solomons Island Rd. Edgewater, MD 21037 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician/ DINATION DNEMMONIA disease or condition Medical resulting in death) sequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examir Cause (Disease or injury that initiated events resulting in death) Last attending physician and for use as the burial-trar Due to (or as a consequence of): Physician/Medical Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month 4 ☐ Pregnant at time of death 9 ☐ Unknown 1 ☐ Yes 2 L 9 ☐ Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? q Division of Vital Records, Completed 1 Yes 2 No 3 Probably 4 Unknown Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 1 🗌 Yes 2 🗌 No Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? မ 1. Inpatient 2 ER/Outpatient 3 DOA 4 \square Nursing Home 5 \square Residence 6 \square Other (Specify) funeral 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Certificate: 1 Natural 28d. Describe how injury occurred the Hospital or Attending n 24 hours arter consider Funeral Director: After contacts filled in by the fur 5 Pending injury work? 2 Accident
3 Suicide
4 Homicide 2 No Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Signature and title of certifier ho completed cause of death (Item 23a) (Type, Print) ENTA

3. Time of Death

10d. Inside City Limits

and Death

Year

1 🗆 Yes 2 🛣 No

023 W

Registrar DHMH 17 Rev 06-2011 31. Date filed (Month, Day, Year)

MAR 05

32 Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) Eric Anderson 2. Date of Death 3. Time of Death Physician/ Month 02 3:00AM 20^{rear}2 Medical 4a. Facility Name (if not institution, give street and number)
St. Thomas More Rehab City, Town, or Location of Death **Examiner** 4c. County of Death Center Hyattsville Prince Georges Social Security Number 579-82-4750 7. Age (In yrs. last birthday) 42 yrs. 6 Sex If Under 1 Year If Under 24 Hrs. 8. Date of Birth Funeral 9. Birthplace (State or Foreign Days 1 🔀 M 2 🗆 F Hours 99777 17969 **Director** Usual Residence of Decedent 28a-f shov 10a. State 10b. County 10c. City, Town or Location Page 1 and 2 should be filed within 72 hours after death with the Maryland 10d. Inside City Limits Funeral Director MD Capitol Heights Prince Georges must be notified 1X Yes 2 ☐ No 10e. Street and Number 4159 Southern Ave. #203 10f. Zip Code 20743 ō 10g. Citizen of What Country? items 23a USA 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14 Race - American Indian Black White, etc. 1 Never Married 2 Married 0 Completed by Yes Yes Baltimore, Maryland 21215-0036 1 ☐ Yes 2 1 No Specify: "natural", Specify 3 Widowed 4 Divorced Year or Dates other than "naturent, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Restaurants Manager Be 17. Eathers Name (First, Middle, Last) WIIIIam Earl Anderson 18. Mother's Name (First, Middle, Maiden Surname) Verdie Lipscomb and Mental F is marked of ဂ္ 19a. Informant's Name/Relationship (Type, Print) 9b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zio Code) 4159 Southern Ave. #203 Capitol Heights, 20743 permit. Page 1 and 2 sh Department of Health an Important: If item 27 is any injury or other trau once. Mary Lipscomb/ sister 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other) 20c. Location - City or Town, State Riverdale, MD 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Riverdale Park NEWastington Signature of Funeral Service Licensee Dunn & Sons-5635 Eads St. mo/388 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ therosciero to disease or condition Medical resulting in death) ue to (or as a consequence of) Examiner Sequentially list conditions, Examine ri any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence on: burial-trar resulting in death) Last Due to (or as a consequence of) physician Physician/Medical the Hospital or Attending Physician: The law requires that the death certificate be entined the use after death.

The Funeral Director: After this certificate has been signed by the attending physicial makersal Director. After this certificate shall be defacted by the sattending by the funeral director, page 2 should be detached for use as the burn Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 1 Live Birth
4 Pregnant a
9 Unknown 3 Ectopic pregnancy in the past 12 months? Day Year Pregnant at time of death 5 Other (specify) 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 3 Probably 4 ☐ Unknown 1 Yes 2 No 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy perform death? 2 No 25. Was case referred to medical To Be 26. Place of Death (Check only one) examiner? 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 1 ☐ Yes Certificate: 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending 2 No Investigation 6 Could not be Accident Suicide 3 ☐ Suiciae 4 ☐ Homicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completed filled in by determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 7 29b. Signature and title of certifier

State

31. Date filed (Month, Day, Yea

7 2012

MAR 0

Name and address of person who completed cause of death (Item 23a) (Type, Print)

D006368

29d. Date signed (Month, Day, Year)

2012

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hydiene. Baltimore, Maryland 21215-0036 To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. Division of Vital Records, P.O. Box 68760

			Plea	ase Type or							-			gible.				
		For State Registrar		State	of Marylar		epartm <i>Certifica</i>		Health and Death	d Me		gien Reg. N	00	112		ΩΩ'	7	1
hysicia	n/	1. Decedent's Name									2. Date of Dea	ath		Year	- 1	Time of I		_
Médic	al	Carolyn 4a. Facility Name (if		ia Adams	mher)		1h C	ity Town o	r Location of Dea		larch 1		2012			9:10	ΑN	1
Examin	er			's Hospit			46.0		4c. County of Death Prince George's									
uneral irector		5. Social Security No. 579–48–		6. Sex 1 ☐ M 2 🖾 F	7. Age (In yrs.		Monti	der 1 Year ns Days	If Under 24 Hi		B. Date of Birtl (Month, Day)	COL	intry)	(State or		
		Usual Residence of	of Decedent	1 L M 2 ES F							July 23	3, 1	934	Seatt		Wash		
a-f sho fied at	ector	10a. State Maryland	10b. County	e George'			or Location ver Hi	116					10d. Inside City Limits 1 ☑ Yes 2 ☐ No					
or 28 se noti	I Dire	10e. Street and Nun		c deorge	5 110	indov	10f. Zip Code						Citizen of	What Co				_
ms 23a must b	Funeral Director	6914 Va	rnum Si						784	10 11			USA					_
or iter miner	by Fu	11. Marital Status 1 Never Marri	ied 2 🗌 Mari	ried Armed Fo	2 🔀 No	.S.	If Yes, s	pecify Cuba	lispanic Origin? (an, Mexican, Pue	(Specif erto Ric	fy Yes or No- can, etc.)			ce - Amer ck, White		dian,		
tural", al Exa		3 Widowed		Teal of Di	/e ates.				Specify:				Specify	· Wh	nite	:		
an "na Medic	Completed	(Spe	cify only highe	nt's Education est grade completed, College (1		1 (Decedent's U 'Give kind of l ife. DO NOT	work done	during most of w	orking			Kind of B					
ther th	Be Co	10			-4 01 3+)	W	aitres	S					staur		Ind	ustr		
rked of	To B	17. Father's Name (First, Middle, Last) Malcolm Laurel Nickerson 18. Mother's Name (First, Middle, Maiden Sumame) Margaret Bonnie McLeod																
is mar		19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State																
tem 27 ther tr		Stephen C. Adams / Son 6914 Varnum Street, Landover Hills, M 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - Ci											-			-		
int: If ii			X Cremation	3 Removal from Repecify)	State	cemetery	crematory o	or other plac					exand	_			ia	
Important: If them Z7 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		21. Signature of Fu	reral Service L	icensee	e. R.				ss of Facility	Ome	ъ	47	739 B	alti	mor	e Av	enu	ie
				complications that only one cause on ea		th. Do no							alls	, , , , ,	App	proximate rval Betw		1
sician/		Immediate Cause (disease or conditio	Final	- a FA		CAR	MAC	ALL	HALHM	ľΑ						set and D		
ledical aminer		resulting in death) Due to (or as a consequence of):																
#2	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying b. Due to (or as a consequence of):											\neg					
and II-trans	Examiner	Cause (Disease or injury that initiated events cuesting in death) Last Due to (or as a consequence of):																
ıysician ne buri	a																	
ding ph se as th	Physician/Medic	IF FEMALE:		23c If yes out	tcome of pregna	ancv											-	
e atten	iciar	23b. Was decedent in the past 12 r 1 \(\sum \) Yes 2	nonths?	1 🔲 Live 4 🔲 Preg	Birth 2 🗀 Fet nant at time of	al death	3 Ectop 5 Other		су					I. Date of delivery Month Day Year				
d by the		9 Unknown	icant conditio	9 Unki		sultina in	the underlyin	ng cause di	ven in Part I		23e. Did to	hacco	LICO CONT	ribute to	the cou	use of de	oth?	_
signe	ed by										1 🗆 Y		2 No			4 🗆 U		'n
as beer 2 shou	Completed										24a. Was a					ndings av		
cate h												med?	,	death? 1 Yes				
s certif directo	To Be	25. Was case referred examiner? 1 Yes 2	d to medical	Hospital:	Inpatient 2	2 -p/Out	nationt 3	1.00	er:		nly one) e 5 □ Reside		6 \(\tau \) Oth	ar (Canai	i4 d			
fter this		27. Manner of Death	5 Pendin	28a. Date		28b. Ti		28c. Injur	y at	\neg	d. Describe h				17)			
ctor: A	Certificate	2 Accident 3 Suicide	Investig 6 ☐ Could	gation not be	of Injury - At h	ome, farr	n, street, fact		Yes 2 ☐ No	28	f. Location (Si	treet a	and Numh	er or Run	al Rout	te Numbe	er	_
a l Dire Ied in t		4 U Homicide	determ		ing, etc. (Specif						City or Towi							
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Medical		Medical E	Physician: To the beautiner: On the base Nurse Practitioner	sis of examinatio	n and/or	investigation,	in my opinie	on, death occurre	d at th	e time, date ar	nd plac	ce, and du	e to the c	ause(s)		ner stat	ted.
To th	_	29b. Signature and		-				9c. Licens	e number				ate signe	d (Month	, Day, Y			
3		30. Name and addre	ess of person	who completed caus	se of death (Iten	n 23a) (T _\	/pe, Print)		873			3/		2016				_
44		JANAS		ESTER,	M)	300	1 400	SPITA	· SRIVA	E	CHEVE	KU	4, ~	15	20	785		
Stat Registra		MARUZZ	012	Jenson 32. R	ler istrar's Signa													

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. For State Registrar State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ ZG Grace Leona Adkins Medical acility Name (if not institution, give street and number, 4b. City Town, or Location of Death Ac. County of Death **Examiner** Lisbur Pice the Comico Age (In yrs. last birthday) If Under 24 fars 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Hours Min (Month, Day, Year, Country **Director** 219-14-2912 1 🗆 M 2 🖾 F Yrs 88 July 6, 1923 Delaware Usual Residence of Deced ortant: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10d. Inside City Limits the Maryland 10c. City, Town or Location Director 1 X Yes 2 No MD Wicomico Salisbury 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Completed by Funeral with 1 21801 U.S.A. 1514 Riverside Drive within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates Specify: 3 X Widowed 4 Divorced white 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4 or 5+) and Mental Hygiene is marked other that home 12 homemaker Be Page 1 and 2 should be filed ment of Health and Mental Hy Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Pearl Williams Vogle Moore 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health a Important: If item 27 is 21875 9201 Bi-State Blvd. Delmar, MD Edward A. Adkins (Son) 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 X Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) 4 ☐ Donation 5 ☐ Other (Specify) Stephens Cemetery 3-2-2012 Delmar, Delaware 21. Signature of Funeral Service Licenses 22. Name and Address of Facilit Short Funeral 13 East Grove any Home Street Short Delmar, DE 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death Physician/ CARBBROVAS CULAR ACCIDENT disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner YPRRTRN 510N Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner Due to (or as a consequence of). use as the burial-transi and that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 - Ectopic pregnancy in the past 12 membs? Month Day Year Pregnant at time of death 5 Other (specify) been signed by the a should be detached ☐ Yes 2 to ☐ Unknown ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Triknown 24b. Were autopsy findings available prior to completion of cause of death?

1 \(\sum \text{Yes} \) 2 \(\sum \text{Yes} \) 24a. Was an autopsy performed this certificate has Ves 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner' Other: 4 Nursing Home 5 Residence 2 PNO Hospital: Certificate: To 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred After injury Natural Natural 5 Pending Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) . Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifie (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year,

The state of the s

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Hadison Margaret ,201²2 MARCH 10 3:40P M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death CHARLES GENESIS WALDORF CENTER WALDORF Social Security Number 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Days Hours Min 1 🗆 M 2 🔽 578-03-7118 97 WASH **Director** -14-1915 D.C Usual Residence of Decedent or 28a-f show notified at 10a. State 10b. County filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director WALDORF CHARLES MD. 1 Yes 2 No 10e. Street and Number 10f. Zip Code ò 10g. Citizen of What Country? "natural", or items 23a o Funeral 3050 OLD WASHINGTON ROAD 20601 U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian Armed Forces?

1 Yes 2 No Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 😾 No Specify: Specify: WHITE 3

Widowed 4 □ Divorced Completed event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working MARSHALL HALL life. DO NOT use retired) and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) AMUSEMENT PARK PARK MANAGER 12th Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be f Department of Health and Menta Important: If item 27 is marked any injury or other traumatic ev 2 VIRGIE ANNA BURGESS FREDERICK WILLIAM HENNINGS 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code -DAUGHTER 3050 OLD WASH.RD. WALDORF, MD. 20601 ELIZABETH MORELAND 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State TRINITY MEM.GARDENS 3-15-12 WALDORF, MD. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses M00479 RAYMOND FUNÉRAL SERVICE, P.A. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dyir shock, or heart failure. List only one cause on each line. MARYLAND 20646 such as cardiac or respiratory arrest, PLATA Approximate Interval Between Immediate Cause (Final nrive Onset and Death Ure Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner send Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events resulting in death) Last Examine Due to (or as a consequence of or Attending Physician: The law requires that the death certificate be executed the burial-transif and Due to (or as a consequence of) attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 as IF FEMALE nse 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No þ 5 Other (specify) Month Day Year Pregnant at time of death 1 Yes 2 Unknown the signed by 23e. Did tobacco use contribute to the cause of death? þ cosunoma 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Munknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 performe undi dineme this certificate 2 No 1 Yes 25. Was case referred to medical examiner? 26. ace of Death (Check only one) funeral director, Be Hospital: 2 **X** No Other: 1 🗌 Yes ည 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred within 24 hours after death. To the Funeral Director: After 1 Natural 5 Pending Accident 1 Yes 2 No Investigation the Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Location (Street and Number or Rural Route Number, City or Town, State) completed filled in by determined Hospital Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D71199 · m 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) on Blud Steb, Glen Burne, MD, 21061

Registrar

DHMH 17 Rev 7/2009

State

31. Date filed (Month, Day, Year,

2 0 2012

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Physician/ Month 28 2012 Shirley Louise Barr 01:20 A M Medical 4a. Facility Name (if not institution, give street and number) 4b City Town or Location of Death 4c. County of Death **Examiner** Suburban Hospital Bethesda Montgomery 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) **Funeral** Hours 12/25/1924 Pennsylvania Director 579-20-7642 87 1 □ M 2 X F Usual Residence of Deced 28a-f show 10d. Inside City Limits 10a. State 10b. County 10c. City. Town or Location Director notified 1 Yes 2X No MD Potomac Montgomery t be pr 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? must U.S.A. 8113 Horseshoe Lane 20854 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Examiner Was Decedent Ever Armed Forces?

1 Yes 2 No If Yes, Give Year or Dates. Black, White, etc 9 þ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White "natural", 3 Widowed 4 Divorced Completed Medical 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working Hygiene. life. DO NOT use retired) College (1-4 or 5+) Elementary/Secondary (0-12) the Homemaker Own Home and Mental Hygie is marked other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Naomi Florence Pries John William Mann, MD 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 8113 Horseshoe Lane, Potomac, MD J. Frederick Barr/Husband 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Page 1 a Department of H Important: If ite any injury or ot 1 Burial 2 XCremation 3 Removal from State Metropolitan Crematory 03/02/12 Alexandria, Virginia 4 Donation 5 Other (Specify) 22. Name and Address of Facility 21. Signature of uneral Service Lice 7211 Lee Highway, Falls Church, VA 22046 complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, 23a. Part 1. Enter shock, or heart failu Immediate Cause (Final failure only one cause on each line Onset and Death Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): that initiated events resulting in death) Last Due to (or as a consequence of) the burial-Physician/Medical as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 🔀 No Day Yea Pregnant at time of death 9 Hinknown 9 Unknown þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy Yes Division of Vital or Attending Physician: after death. 25. Was case referred to medica 26. Place of Death (Check only one) Be examiner? Hospital: 2 No 1 🗌 Yes ပ 1 ☐ Inpatient 2 ► ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify, 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 X Natural 2 Accident 5 Pending 1 Yes 2 No Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number, determined building, etc. (Specify) within 24 hours a

To the Funeral D To the Hospital Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. minatic, and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical Examiner: On the basis of exa Gartifying Nurse Executioner To t 29b. Signature and ∕itle of certifier 29d Date signed (Month, Day, Year) 30. Name and adgrees of person who completed cal 1044 10 ward 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 06-2011

Registrar

12-01641 Wesley Major B	ricko				,28a-f,per monk. Ensure All of Health and Me		9-12 sm .egible.		
		1- For State Registrar		Certificate o			Reg. No.	2012	0871
Physici Medical Exami		1. Decedent's Name (First, Middle,La		Tw		Date of D Month	Day 9 26, 2012		Time of Death 0503 hrs
·	IIIGI	Wesley Major E		Jr.	4b. City, Town, or Locatio			unty of Death	
		Peninsula Regional Medic	cal Center		Salisbury		Wice	omico	
Funeral Director			ex 7. Age (I	In yrs. last birthday) Yn	Months Days Hou	nder 24Hrs. 8. Date of urs Min. 10 –	Birth(MM/DD/Y	Foreign	
iny		Usual Residence of Decedent 10a. State 10b. County	10	c. City, Town or Loca	tion			10	0d. Inside City Limits
od thow a	L	MD Wicomi	CO	Salisbur	·v			1	Yes 2 X No
larylar 28a-f	Director	10e. Street and Number		Ballbaal	10f. Zip Code		10g. Citizen o	of What Country	?
the Na or 2	Dir	1402 South Sal	lisbury Bl	.vd.	21801		USA		
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any jujury or other traumatic event, the Medical Examiner must be notified at once.	Funeral	11. Marital Status 1 Never Married 2 Married	12. Was Decedent Ev Armed Forces?	erin U.S. 13. W. Air Force	as Decedent of Hispanic C Yes, specify Cuban, Mexic	can, Puerto Rican, etc.)	'	Race - Americar White, etc. cify:Black	
irs afte ural?	by	3 Widowed 4 X Divorced 15. Decedent's Education (Specify of	or Dates: If Yes, Give Year 197 or Dates:		Yes 2 X No special No	·		of Business/Indu	
72 hou	Completed	Elementary/Secondary (0-12)	College (1-4 or 5+)	during n	nost of working life. DO NO				,
036 nithin and sine.	Пp	12		Sheet	Metal Fab	oricator	HVAC	Corp.	
21215-0036 uild be filed within 7 Mental Hygiene. marked other than		17. Father's Name (First, Middle, Last	,			ner's Name (First, Middl		ame)	
2121 Ild be i Mental narke event	To Be	Wesley Brickou 19a. Informant's Name/Relationship (*	ls, Sr.	19h Mailin	g Address (Street and N	ry A. Wil		Town State 7i	in Code)
MD 2 nd 2 shou alth and N m 27 is r	ř	Nadine Sample			Nutters (
l and Health		20a. Method of Disposition		20b. Place of Dispos	sition (Name of cemetery,			tion - City or Tox	
MOF Pages ent of at: If		1 Burial 2 Cremation 3 4 Donation 5 Other Specify	_	va cematory or of		3-6-201	2 Hurl	ock. M	MD.
Baltimore, permit. Pages I an Department of Hes Important: If ite	- 6	21. Signature of Funeral Service Light		22.	Name and Address of Fagi	шту 917 W.	Isacel	la St.	a (*)== 7.
	-	Jugot of a	17	Fu	neral Home	e Salisbu	ry, MD	21801	
Physician /Medical axaminer		Part I. Enter the disease, or comfailure. List only one cause on e Immediate Cause (Final disease a or condition resulting in death)		toxication		s cardiac or respiratory	arrest, shock, o		Approximate Interval Between Onset and Death
` '		Sequentially list conditions, b							
	Examiner	if any, leading to immediate cause. Enter Underlying Cause	Due to (or as a consequ	ence of);					
	хап	(Disease or injury that initiated c. events resulting in death) Last	Due to (or as a consequ	ence of):				-	
ecuted and transi		d							
be exercian	dic								
Division of Vital Records, P.O. Box 68760, To the Hospital or attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit	Physician/Medical	IF FEMALE: 23b, Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	23c. If yes, outcome of 1 Live birth 4 Pregnant at time	2 Fe	etal death 3 Ecto	pic pregnancy	23d. Dat Mon	ite of delivery ith Day	Year
the de	Phy	Part II. Other significant conditions	9 Unknown	ut not resulting in the	underlying cause given in	Part I 23e Die	d tobacco use c	contribute to the	cause of death?
P.C ss that gned b	á	·		_	,, g				ly 4 🗸 Unknown
Division of Vital Records, P.O. ral or Attending Physician: The law requires that the safter death. 11 Director: After this certificate has been signed by led in by the funeral director, page 2 should be detach	Completed					pe	topsy rform <u>ed</u> ?	prior to com death?	sy findings available pletion of cause of
E The tiffcat or, page	ပ္ခို	25. Was case referred to medical	·	<u> </u>	26 Place of Deal	1 ✓ Ye th (Check only one)	s 2 No	1 Yes	2 No
Vita ysicia his cer direct	å	examiner? 1 ✓ Yes 2 No	Hospital: 1 Inpatient	2 FR/Outpatien	10.0		Residence	6 Other:	
Of of ug Ph.	2	27. Manner of Death	28a. Date of Injury (Month, Day,Year)	28b. Time of	Injury 28c. Injury at Wo	i .	e how injury oc	curred	
ion teath. tor:	atio	1 Natural 5 Pending 2 Accident Investigat	C1 2 2C		00 am 1 Yes 2	x No unknov	m		
ivis lor At after of Direc	흹	3 Suicide 6 X Could not	be 28e. Place of Injury		et, factory, office building,	etc. 28f. Location or Town	n (Street and No n, State) 140	umber or Rural 2 S. Sa1	Route Number, City
D sepital hours uneral	Certification:	4 Homicide determine 29a. Certifier 1 Certifying Physic	Toposis, FO	und:Reside		Blvd.	Apt 1	Salist	oury,Md.
Divisior To the Hospital or Attend within 24 hours after death. To the Funeral Director: completely filled in by the	Medical	(Check only	r:On the basis of examin	-	rred at the time, date and pation, in my opinion, death				ause(s)
To To Com	Med	29b. Signature and title of certifier	and manner stated.		29c.License numbe			signed (Month,	
N.	127	auet -			O.C.M.E.		Februar	ry 27, 2012	
147		20 Name and address of names who	sampleted saves of deat	th (Itam 22a)					

Registrar

DHMH 17 Rev 1/2001 OCME 2006

State

31. Date filed (Mouth) (Day, West) 2012

Ana Rubio MD. Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223

Date filed (Modific Pay, Near) 2012 32 egistrar's Signature

UUNE

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
 Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 2350 P.M Janie Ann Bailey Medical 4a. Facility Name (if not institution, give street and number) Examiner 4c. Counfy of Death A4136419 KICOMICE KegION AL If Under 1 Year If Under 24 Hrs Age (In yrs. last birthday, 9. Birthplace (State or Foreign **Funeral** Days (Month, Day, Year Hours Director 221-60-1170 1 □ M 2 🔀 F 47 -7-1964 MD artment of Health and Mental Hygiene. ortant: If item 27 is marked other than "natural", or items 23a or 28a-f show Injury or other traumatic event; the Medical Examiner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No MD Somerset Marion 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? by Funeral PO Box 18 21838 USA be filed within 72 hours after death 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-11. Marital Status 14, Race - American Indian, Armed Forces If Yes, specify Cuban, Mexican, Puerto Rican, etc. Black, White, etc. 1 ☐ Yes 2 X No If Yes, Give 1X Never Married 2 ☐ Married 3altimore, Maryland 21215-0036 Speci Black 1 ☐ Yes 2 X No Specify: Completed 3 Widowed 4 Divorced Year or Dates. 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Domestic Worker Unk Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 0 James Bailey Hilda Price 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If item 27 is any Injury or other trae <u> Virginia M. Wise/Sister</u> 11450 Pine Pole Rd, Princess Anne, MD 21853 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other Disposition) Date 20c. Location - City or Town, State 1 Burial 2 XCremation 3 Removal from State Cremation, 3-5-20124 ☐ Donation 5 ☐ Other (Specify) Direct Dover, DE 22. Name and Address of Facility 917 W. Bennie Smith Funeral Home Salisbu 21/ Signatura Funeral Service Licensee Isabella St. sell Salisbury, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate nterval Between Immediate Cause (Final Onset and Death Physician/ diomi disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** orona Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that Initiated events Due to (or as a consequence of) Exami the burial-trar resulting in death) Last Due to (or as a consequence of): attending physician for use as the buria Physician/Medical certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Cther (specify) in the past 12 months? Day Pregnant at time of death 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🂢 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an Jas page 2 autopsy death? the Funeral Director: After this certificate appletely filled in by the funeral director, pag 2 No Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital 2 🛛 No 1 Inpatient 2 ER/Outpatient 3 DOA မ 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 1 X Natural 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred or Attending F after death. injury 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State, the Hospital hours 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 To the only one 29b. Signatu

Registrar
DHMH 17 Rev 06-2011

100 €.1

Registrar's Signature

30. Name and address of person who completed gause of death (Item 23a) (Type, Print)

2

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2 1 2

		-		ertificate of Death	Reg. No	0010 00717					
	Physicia	n/	1. Decedent's Name (First, Middle, Last)		2. Date of Death Month Da ebruary 29	3. Time of Death 4:30 A M					
	Medic Examin		Harry Devon Campbell 4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of Death		County of Death					
المديدة)		7420 Dominion Drive	0xon Hill		Prince Georges					
	Funeral Director		5. Social Security Number 578-68-8002 Usual Residence of Decedent 6. Sex 1 X M 2 F 7. Age (In yrs. last birthday) 64 Yrs.		3. Date of Birth (Month, Day, Year) 2/11/1947	9. Birthplace (State or Foreign Country) New York					
	land show dat	tor	10a. State 10b. County 10c. City, Town or L	ocation		10d. Inside City Limits					
	Mary 28a-f	Director	Maryland Prince Georges Oxon Hi			1 🗌 Yes 2 😾 No					
	s 23a or	Funeral D	10e. Street and Number 7420 Dominion Drive	10f. Zip Code 20745		tizen of What Country?					
9036	within 72 hours after death with the Maryland giene. er than "natural", or items 23a or 28a-f show, the Medical Examiner must be notified at	b	11. Marital Status 1 ☑ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1∑ Yes 2 ☐ No If Yes, Give Year or Dates. Vietnam	. Was Decedent of Hispanic Origin? (Specifif Yes, specify Cuban, Mexican, Puerto Ric 1 ☐ Yes 2X No Specify:		14. Race - American Indian, Black, White, etc. Specify: Black					
Maryland 21215-0036	be filed within 72 hours ntal Hygiene. ed other than "natura; event, the Medical E.	Completed	(Specify only highest grade completed) (Given Elementary/Seconday (0-12) College (1-4 or 5+)	edent's Usual Occupation e kind of work done during most of working DO NOT use retired)		ind of Business Industry					
d 21	교육도등	l as l	12 Me	chanic 18 Mother's Name (F	First, Middle, Maiden	overnment Sumame)					
/lan	ould be file nd Mental marked c	2	Charlie Campbell	Marion Ha							
	2 shouth and the and the strain trains			ling Address (Street and Number or Rural R 14th St. NE Washing							
Baltimore,	nit. Page 1 and 2 artment of Healt ortant: If item 2 injury or other:		20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)	position (Name of ematory or other place) coln Cemetery 03/06,		ocation - City or Town, State					
Balt	permit. Page Department of Important: If any injury or once,		21. Signature of Funeral Service Licens le	22. Name and Address of Facility Fort 401 Bladensburg Road	Lincoln E	Funeral Home					
	Physician/ , Medical	200	23a. car) 1. Enter the disease, or complications that caused the death. Do not en shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of):		espiratory arrest,	Approximate Interval Between Onset and Death					
	Examiner		Due to (or as a consequence of).	cular Disease		years					
	sd sit	Examiner	equentially list conditions, any, feating to immediate ause. Enter Underlying ause (Disease or linjury								
	certificate be executed anding physician and use as the burial-transit	al Exa	that initiated events resulting in death) Last C. Due to (or as a consequence of):								
760	cate b physic	Medical	d								
. Box 68760	law requires that the death certificate be executed as been signed by the attending physician and a 2 should be detached for use as the burial-transi	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No g ☐ Unknown IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live Birth 2 ☐ Fetal death 3 4 ☐ Pregnant at time of death 5 9 ☐ Unknown	Ectopic pregnancy Other (specify)		23d. Date of delivery Month Day Year					
ds, P.O.	requires that the been signed by should be detact	by	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.		use contribute to the cause of death?					
Division of Vital Records,	The sate h	Completed			24a. Was an autopsy performed? 1 Yes 2 No	24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No					
/ital	Physician: this certific ral director,	To Be	25. Was case referred to medical examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpati	26. Place of Death (Check of Other:	nly one) e 5 X Residence 6	C Chhar (Canaita)					
n of \	ding h. After fune		27. Manner of Death 1 Natural 5 Pending (Month, Day, Year) 28b. Time (Month, Day, Year) 29b. Time (Month, Day, Year)		d. Describe how injur						
Divisio	al or Attenos after deat Birectors din by the	Certificate:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, s building, etc. (Specify)	treet, factory, office 28	f. Location (Street and City or Town, State)	nd Number or Rural Route Number, s)					
	To the Hospital or Atte within 24 hours after de To the Funeral Directo completed filled in by th	Medical	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death 2 Medical Examiner: On the basis of examination and/or inventory only one) 3 Certifying Nurse Practioner: To the best of my knowledge	estigation, in my opinion, death occurred at the	e time, date and place	e, and due to the cause(s) and manner stated.					
			29b. Signature and the of Certifier	29c. License number		ate signed (Month, Day, Year)					
	10		30. Name and address of person who completed cause of death (Item 23a) (Type	ACO00 937	Mar	ch 6, 2012					
	Sta	te.	Melanic V. Rangelds ANP-BC C	1200 Bail Ct. St	e 200, h	orgo Hb 20794					
	Registr		31. Date filed (Month, Day, Year) NAR 0 B2012 August 32. Registrar's Signature								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ Year JIMMIE EARL CONLEY MARCH 2012 Medical :30A 4a. Facility Name (if not institution, give street and number, **Examiner** 4b. City, Town, or Location of Death 4c. County of Death CALVERT MEMORIAL HOSPITAL PRINCE FREDERICK CALVERT Social Security Number If Under 1 Year If Under 24 Hrs. Sex 7. Age (In yrs. last birthday) 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** Months Days Hours (Month, Day, Year) **1**× × M 2 □ F 232-50-5066 Yrs Director AUG.16,1934 W. VIRGINIA Usual Residence of Decedent shov 10a. State 10b. County the Maryland 10c. City, Town or Location 10d. Inside City Limits notified at Director 28a-f MD CHARLES WALDORF 1 Yes 2XXNo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ms 23a or Funeral with 3420 FOREST DRIVE 20601 U. S. A. items 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Examiner Black, White, etc. Yes 2 No
If Yes, Give
Year or Dates. 51 ò ģ 1 Never Married 2 Married Page 1 and 2 should be filed within 72 hours after ment of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify Specify: Completed 3 Widowed 4 Divorced WHITE the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 10 AUTO REPAIR REPAIR MECHANIC Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Ith and Mental H 27 is marked of r traumatic even ၉ OTTIE SYLVESTER CONLEY BERTHA ADELINE MILLER 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) MARGARET CONLEY/SPOUSE Department of Health Important: If item 27 any injury or other tr 3420 FOREST DRIVE WALDORF, MD 20601 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State MARCH Burial 2- Cremation 3 Removal from State TRINITY MEM.GRDNS; 4 ☐ Donation 5 ☐ Other (Specify) 14,2012 WALDORF, MARYLAND 22. Name and Address of Facility RAYMOND FUNL. SERVICE, P.A. enl das 5635 WASHINGTON AVE., LA PLATA, MD M00641 20646 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ m, 110 Medical resulting in death) (or as a consequence of Examiner MIT Sequentially list conditions, if any, leading to immediate 1)151.11 cause. Enter Underlying Exami Cause (Disease or linjury burial-transi 100 Ü that initiated events resulting in death) Last and Due to (or as a consequence of) attending physician for use as the buria Physician/Medical death certificate be Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month Dav Year 5 Other (specify) Pregnant at time of death signed by the at d be detached for 9 Unknown Hospital or Attending Physician: The law requires that the P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? ò Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ onknown Completed should peen 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an page 2 s autopsy performed 24 hours at er dea h. Funeral Director: After this certificate Division of Vital funeral director, 25. Was case referred to medica Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) မ 1 Tyes 1 Impatient 2 ER/Outpatient 3 DOA Manner of Death Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred 1 Natural 5 Pending injury Accident Investigation completed filled in by the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Lectifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check the only one) within To the 29b. Signature and title of cer 29d. Date signed (Month, Day, Year) 29c. License number ρ 6 30. Name and addres to completed cause of death (Item 23a) (Type, Print)

Registrar
DHMH 17 Rev 7/2009

State

31. Date filed (Month, Day, Year)

32. Registrar's

100 Hospital Rd Prince Frederick MD 201678

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		CA-A-	partment of Health and Mer	ntal Hygien	е
		Registrar 1. Decedent's Name (First, Middle, Last)	ertificate of Death	Reg. N	to the total total
Physic		Coolin Edward Donnia		Date of Death Month	Day Year 3. Time of Death
Med Exam			4b. City, Town, or Location of Death		c. County of Ceath
and the same	Į.	PENINSULA KRANAL MEGLERI CENTU	5AU136N14		HICOMICO
Funera Directo	_	5. Social Security Number 6. Sex 7. Age (In yrs. last birthday 1 M 2 F 70 Yrs.	Months Days Hours Min.	Date of Birth (Month, Day, Year)	_ **
d d	٦.	Usual Residence of Decedent		4/1941	MD
arylan a-f sh ffied a	Funeral Director	Inc. City, lown or l			10d. Inside City Limits 1 ☐ Yes 2 🎛 No
the M or 28 e noti		MD Wicomico Willards 10e. Street and Number	10f. Zip Code	10g. C	Citizen of What Country?
n with is 23a nust b	nera	5565 Denmond Place	21874	USA	,
r deatl			3. Was Decedent of Hispanic Origin? (Specify If Yes, specify Cuban, Mexican, Puerto Rical	Yes or No- n, etc.)	14. Race - American Indian, Black, White, etc.
Naryland 21215-0036 should be filed within 72 hours after death with the Maryland and Mental Hygiene. Is marked other than "natural", or items 23a or 28a-f show raumatic event, the Medical Examiner must be notified at	ed by	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 🕱 No If Yes, Give Year or Dates,	1 ☐ Yes 2 🙀 No Specify:		Specify: white
5-0 2 hour "natu	plet	15. Decedent's Education 16a. Dec (Specify only highest grade completed) (Giv	cedent's Usual Occupation re kind of working most of working	16b.	Kind of Business/Industry
ithin 7 ene.	Completed	Elementary/Secondary (0-12) College (1-4 or 5+) life.	DO NOT use retired)	Pe	erdue Farms
Maryland 21215-0036 2 should be filed within 72 hours after th and Mental Hygiene. 27 is marked other than "natural", o traumatic event, the Medical Exam	Be	17. Father's Name (First, Middle, Last)	18. Mother's Name (First		
arylance ould be file ould be file marked o marked o	임	Roy E. Dennis	Maggie J.	Truitt	,
Maryla Should be h and Mer T is marke traumatic			iling Address (Street and Number or Rural Rou		
	1	Robert E. Dennis (son) 5561 20a. Method of Disposition 20b. Place of Disp	Archie Jones Rd. Wi		
		1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State cemetery, cr	ematory or other place) le Cemetery 3/7/201		coation - City or Town, State
Baltimore, permit. Page 1 and Department of Hea Important: If item any injury or other once.			22. Name and Address of Facility The B	urbage E	uneral Home
		23a. Part 1. Enter the disease, or complications that caused the death. Do not en	108 William St. Berl		Approximate
- Ph_sician	ė.	shock, or heart failure. List only one cause on e.ch line. Immediate Cause (Final disease or condition	Lyocardial I	u face	Interval Between Onset and Death
Medica Examine		resulting in death) a. Due to lor as a consequence of):	CG OCCOGIGITATION	Torc	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,
LAGITITIO		Sequentially list conditions, b.	Tray Artery	Disc	ruse
ted I ansit	dical Examiner	if any, leading to immediate cause. Enter Underlying Cause. Enter Underlying Cause (Disease or Injury	/		
execu an and rial-tra	EX	that initiated events c. The property of the			
ate be	dica	d			
y. F. C. BOX 08 / 00 is that the death certificate be executed gned by the attending physician and be detached for use as the burial-transit	Physician/Me	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy			
box death c le atten ed for u	iciai	in the past 12 months? 1 Live Birth 2 Fetal death 3 1 Yes 2 No 4 Pregnant at time of death 5	☐ Ectopic pregnancy ☐ Other (specify)		23d. Date of delivery Month Day Year
t the d by the	Phys	9 Unknown	T		
Lires that signed ald be de	à	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.		use contribute to the cause of death? □ No 3 □ Probably 4 □ Unknown
ecords, e law requires has been sig	Completed			24a. Was an autopsy	24b. Were autopsy findings available prior to completion of cause of
Nutal neco		25. Was case referred to medical		performed?	death?
VICAL /sician: s certific	To Be	examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient	26. Place of Death (Check only Other:		
o Phy Ter thi		27. Manner of Death 1 Natural 5 Pending (Month, Day, Year) injury	f I and a second	5 □ Residence © Describe how injui	
VISION or Attendir fler death. irector: Af	Certificate:	2 Accident Investigation 3 Suicide 6 Could not be	M 1 Yes 2 No		
al or Ai s after or Direct or Direct or by		4 Homicide determined 28e. Place of Injury - At home, farm, st building, etc. (Specify)		ocation (Street and City or Town, State	nd Number or Rural Route Number, e)
DIVISION OF VITAL RECORDS, F.O. BOX 08/00 WATCH TO the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transic.	Medical	29a. Certifier (Check (Check (Check) 1 Certifying Physician: To the best of my knowledge, death	Stigation in my opinion death occurred at the ti-	me date and place	and due to the cause(s) and manner stated
To the vithin To the compl	Σ	only one) 3 Certifying Nurse Practitioner: To the best of my knowledg 29b. Signature and title of the control o	e, death occurred at the time, date and place, ar 29c. License number	and due to the cause 29d. Da	e(s) and manner as stated. tte signed (Month, Day, Year)
		> X Ken	232212		3/5712
ET	60	29b. Signature and title of sentier 30. Name and address of person who completed cause of death (Item 23a) (Type, Hephin Scient M.D. 100 B. Carroll 31. Date filed (Month, Day, Year) 32. Registrar's Signature	St. SAUSBURY, M.	20 2/8	0/
Sta Registr	te	31. Date filed (Month, Day, Year) 32. Registrar's Signature	backer		
negisti	aı	A PEROND PARTY			

Please Type or Print in Black Indelible Ink. Ensure	All Copies Are Legible.
State of Maryland / Department of Health and	d Mental Hygiene

erry Clinton D	iaz	State of Maryland / Department of Health and Mental H		201 g. No.	2 08720
Physic Medical Exam		1. Decedent's Name (First, Middle,Last) Terry Clinton Diaz	2. Date of Death Month February 2	Day Year	3. Time of Death 1958 hrs
		4a. Facility Name (if not institution, give street and number) Rt 13 Northbound Between Revells Neck Rd and Perry 4b. City, Town, or Location of Death Westover		4c. County of Dea Somerset	th
Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 1 Months Days Hours Min.	-	, 1962 C	
Maryland 28a-f show any 1 at once.	tor	Usual Residence of Decedent 10a. State			10d. Inside City Limits 1 Yes 2 No
MD 21215-0036 2 should be filed within 72 hours after death with the Maryland h and Mental Hygiene. 27si maturally, or items 23s or 23s fibrantic event, the Medical Examiner must be notified at once	Funeral Director	10e. Street and Number 10f. Zip Code 30561 Creek View Drive 21853 11. Marital Status 1 Never Married 2 Married 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No	pecify Yes or No-	White, etc.	rican Indian, Black,
5-0036 led within 72 hours after Hygene. other than "natural", the Medical Examiner	Completed by	3 Widowed 4 Divorced of Yes, Give Year of Dates: 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 8 Disabled		Specify: Whi 16b. Kind of Business Disabled	
MD 21215-0036 11 should be filed within 7 th and Mental Hygiene. 127 is marked other than umatic event, the Medica	To Be Col	17. Father's Name (First, Middle, Last) Lauro Benetiz Diaz 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Relationship)	hel Trav	71S er, City or Town, Stat	
Baltimore, MD 21215-C permit. Pages 1 and 2 should be filed v Department of Health and Mental Hygi Important: If iten 27 is marked oth injury or other traumatic event; the.		Betty Pusey (Mother) 20a. Method of Disposition 1 Burial 2 X Cremation 3 Removal from State 4 Donation 5 Other Specify: 21. Surplus of Burial Service Licensee 26712 Porter Mill Road 20b. Place of Disposition (Name of cemetery, crematory or other place) Pittsville Cemetery 3/8/ 22. Name and Address of Facility	Date	n, MD 218 20c Location - City o Pittsville Villiam St	r Town, State
Physician /Medical Examiner	31 3	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or failure. List only one cause on each line. Immediate Cause (Finel disease or condition resulting in death) a. Gunshot wound of head and neck Due to (or as a consequence of):	e Berli	n, MD 21	
uted d ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Couse (Disease or injury that initiated events resulting in death) Last d.	-		
Division of Vital Records, P.O. Box 68760, To the Hopital or Attending Physician: The law requires that the death certificate be executed within 24 horts after death. To the Funeral Direct death, To the Funeral Direct After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transi	Physician/Medical	UNPENDED AMENDED Second Contributing to death but not resulting in the underlying cause given in Part I.		23d. Date of deliver Month	Day Year
of Vital Records, P.C ng Physician: The law requires that ther this certificate has been signed I meral director, page 2 should be deta	Completed by	25. Was case referred to medical 26.Place of Death (Check of D	24a. Was an autopsy perform	24b. Were at prior to death?	bably 4 Unknown utopsy findings available completion of cause of es 2 No
sion of Vital Attending Physician death. ctor: After this cert y the funeral directo	ation: To Be	examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other 4 Nursing 27. Manner of Death 28a. Date of Injury 28b. Time of Injury 28c. Injury at Work?			r: Scene
Divis To the Hospital or At within 24 hours after d To the Funeral Direct completely filled in by	ical Certification:	3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc.	or Town, Stat Rt 13 Northbour due to the cause(te) and & Revells Neck s) and manner as stat	
To 1 To com	Medical	and manner stated. 29b. Signature and title of certifier 29c. License number O.C.M.E. 30. Name and address of person who completed cause of death (Item 28a)		29d. Date signed (Mo	
E.T Si Regis	5 tate trar	Zabiullah Ali, M.D. Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, 31. Date filed (Month, Day, Year) 2012 Segistrar's Signature A. January B.	MD 21223		
			17.		OCME

12-01987

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Manyland / Department of Health and Mental Hygiene

nristopner Deid	1	- For State Registrar		rtment o tificate o		u ivieritai r	Re	2 0 eg. No.	12 08/2
Physicia ledical Exami		1. Decedent's Name (First, Middle,Last) Christopher Delonte Drake					2. Date of Deat Month March 9, 2		3. Time of Death 0601 hrs
T.		4a. Facility Name (if not institution, give street and number) Civista Medical Center			4b. City, Town, or LaPlata	Location of Deat		4c. County of D	Death
Funeral Director				ast birthday)	If Under 1 Yea			th (MM/DD/YYYY) S	B. Birthplace (State or Greigh Country Wash DC
*ny	F	Usual Residence of Decedent 10a. State 10b. County	10c. City,	Town or Loca	ition				10d. Inside City Limits
	5	MD PG	Ţ	Upper M	Marlboro				1 Yes 2 No
th the Maryland 23a nr 28a-f shn notified at once	Director	10e.Street and Number 11409 Rhodenda Ave.			10f. Zip Code 20772		1	0g. Citizen of What USA	Country?
r death with or items 2:	Funeral			lf '	as Decedent of His Yes, specify Cubar	n, Mexican, Puert		14. Race - A White, e	
b, MD 21215-0036 and 2 should be filed within 72 hours after death with the Maryland teath and Mental Hygiene. tem 27 is marked ather than "natural", or items 23a nr 28a-f she rrammatie event, the Medical Examiner must be nofified at once	<u>a</u>	3 Widowed 4 Divorced If Yes, Give Year or Dates: 15. Decedent's Education (Specify only highest grade cor Elementary/Secondary (0-12) College (1-4 or Colleg		16a. Decede	nt's Usual Occupationst of working life	tion (Give kind of	work done tired)	16b. Kind of Busin	
0036 within 73 ene. er than	Completed	12		Constr	ruction W		- /Cina Baidella 1	Private	
21215-0036 July be filed within 7 I Mental Hygiene. I marked ather than ic event, the Medica	Be Co	77. Father's Name (First, Middle, Last) Scottie Mauney				Christy	Dral		
Baltimore, MD 21215 permit. Pages and 2 should be filed Department of Health and Mental Hy Impartant: If item 27 is marked n injury or other traumatic event, th	P	19a. Informant's Name/Relationship (Type, Print) Christy Drake—Mauney/Mother		73				nber, City or Town,	7
re, M 1 and 2 Health fitem 2	1 1	20a. Method of Disposition 1 X Burial 2 Cremation 3 Removal from St	20b. F		sition (Name of ce		Date Date	20c. Location - C	
Baltimore, Department of He Impartment of the Impartment: If ite	-	4 Donation 5 Other Specify:		surrect	ion Ceme			Clinton	, MD
Balt permit Depart Impar injury		21 Sonatur of Funeral Service Licensee		110	Name and Address	leport I	n. White	Plains.	MD 20695
Physician Medical		23a. Part I. Enter the disease, or complication, that caused failure. List only one cause on each line.		. Do not enter	the mode of dying,	such as cardiac	or respiratory arr	est, shock, or heart	Approximate Interval Between Onset and Death
Examiner	1	Immediate Cause (Final disease or condition resulting in death) a. Heroin In Due to (or as a constitution of the constitution							3331
	<u>-</u>	Sequentially list conditions, if any, leading to immediate b. Due to (or as a cons	equence o	of):					
	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a cons	equence o	of):					
50, te be executed sysician and burial - transit	편 교	d							
60, ate be en thy sician to burial	Medical	IF FEMALE: 23c. If yes, outco	B a-f me of preg	, per	ME g925 3	3/21/12	TRT	23d. Date of de	elivery
Records, P.O. Box 68760, The law requires that the death certificate be icate has been signed by the attending physic page 2 should be detached for use as the bur	Physician/N	23b. Was decedent pregnant in the past 12 months? 1 Live birth 4 Pregnant a 1 Yes 2 No 9 Unknown 9 Unknown	t time of de		etal death 3 Other (Specify)	Ectopic pregr	nancy	Month	Day Year
P.O. By so that the degree by the edges of the detached for the degree of the detached for	by Ph	Part II. Other significant conditions contributing to deal	h but not re	esulting in the	underlying cause	given in Part I.			rite to the cause of death? Probably 4 Unknown
rds, P.C requires that been signed hould be deta	eted t			_			24a. Was	an 24b. We	ere autopsy findings available or to completion of cause of
of Vital Records, ag Physician: The law requir Arther this certificate has been suneral director, page 2 should	Completed		_				1 ✓ Yes	rmed? dea	ath? Yes 2 No
Vital Rec ysician: The his certificate director, page	o Be	25. Was case referred to medical examiner? 1 ✓ Yes 2 No Hospital: 1 Inpati	ent 2	ER/Outpatier		of Death (Chec		Residence 6	Other:
ion of Vita rending Physicis (eath. tor: After this ce the funeral direct	\vdash	27. Manner of Death 28a. Date of Inj (Month, Day,	Year)	28b. Time of		ıry at Work? Yes 2 🗶 No		how injury occurred	
<u> </u>	Certification:	2 Accident Investigation Fd 3/9/	njury - At h		0 am '- eet, factory, office partment		or Town, 8	Street and Number State)3044_00	or Rural Route Number, City
Hospi 24 hou Funer rtely fil		4 Homicide Certifying Physician: To the best of none) 2 Medical Examiner: On the basis of examiner:	ny knowled	ige, death occ	urred at the time, d	ate and place, ar	nd due to the caus	waldort. se(s) and manner a and place, and due	s stated.
To the within To the comple	Medical	29b. Signature and title of certifier			29c. Licens				(Month, Day, Year)
On .		D-WL.			O.C.	M.E.		March 10, 20	012
4		30. Name and address of person who completed cause of Donna M. Vincenti, MD Assistant Medi			0 W. Baltimore	e Street, Balt	imore, MD 21	1223	
S	tate	31. Date filed (Month, Day Year) 32. Regign	ar's Signati	ure					

ORIGINAL

OCME

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death Physician/ EYLER 11: 09 AM IRENE MAR 2012 Medical 4a. Facility Name (if not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death **Examiner** HOWARD COLUMBIA GENERAL thosp I TAL HOWARD COUNTY 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days Hours Min 11/15/1928 212-24-4345 83 Director 1 M 2 X F NY Usual Residence of Decedent 28a-f shov 10c. City, Town or Location 10d. Inside City Limits iral", or items 23a or 28a-f sho Examiner must be notified at 10a. State 10b. County Director 1 Yes 2 X No Carrol1 Westminster MD 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Funeral 4003 Littlestown Pike 21158 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-12. Was Decedent Ever in U.S. 14. Race - American Indian. Armed Forces?

1 Yes 2 No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Never Married 2 Married 12 should be filed within 72 hours and alth and Mental Hygiene.
n 27 is marked other than "natural", or þ Baltimore, Maryland 21215-0036 white If Yes, Give Year or Dates 1 ☐ Yes 2 K No Specify: 3 X Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Assembler Electronic Manufacturer 12 Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) 2 Olive Twitchell Newell G. Wright 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Department of Health are Important: If item 27 is any injury or other traumone. 8626 Park Ave., Bowie, MD Myrten Eyler / son 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of Date X Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) 3/14/2012 Evergreen Cemetery Finksburg, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licen Littlestown. PA 17 4 Little's Funeral Home Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ END CITRENIC OBSTRUCTIVE DISEA STAGE PULMONARY disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner RESPIRATORY FAILURE if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events the burial-transit and Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 as IF FEMALE: nse 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 🔲 Ectopic pregnancy in the past 12 months?
1 Yes 2 No signed by the atte Month Day Year 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 X Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No 24a. Was an or Attending Physician: The law after death. autopsy performed? Yes 2 No filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 \(\text{Nursing Home} \) 5 \(\text{Residence} \) Residence 6 \(\text{Other} \) Other (Specify) 1 Yes 2 No 1 Name of the Impatient 2 ER/Outpatient 3 DOA မ 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: Natural 5 Pending 1 Yes 2 No Accident Investigation 6 Could not be 2 Accidem
3 Suicide
4 Homicide **Director:** 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined To the Hospital o within 24 hours aff To the Funeral Di completely filled in Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check

gn State 29b. Signature and title of certifu

31. Date filed (Month, Day, Year)

D. PATEL

Registrar

DHMH 17 Rev 06-2011

PATRICENT

PHYSICIAN

32. Registrar's Signature

LITTLE

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

10632

D50404

SLEE (11

29d. Date signed (Month, Day, Year)

COLLIMBIA, MD

09, 2012

20044

MAR

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Physician/ Gabriella **Kolus Fekecs** 2012 Medical March q 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Bethesda Montgomery <u>Suburban Hospital</u> 8. Date of Birth (Month, Day, If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) **Funeral** Hours Min Director 224-98-1560 1 🗆 M 2 🗶 F 60 April 25, 1951 Hungary show 10a. State 10b. County 10c. City, Town or Location 10d Inside City Limits Director or 28a-f sl Great Falls VA Fairfax 1 Yes 2 No 10f. Zip Code 10e. Street and Number 0 10g. Citizen of What Country? items 23a or ner must be r Funeral 22066 USA 1130 Edward Drive within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) "natural", or item ledical Examiner n 11. Marital Status Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces?

1 Yes 2 No
If Yes, Give Black, White, etc. 1 Never Married 2 Married ğ Maryland 21215-0036 If Yes, Give Year or Dates. 1 Yes 2 X No Specify Specify: White Completed 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) marked other than Elementary/Secondary (0-12) College (1-4 or 5+) the Own Home Homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental F ပ Lenke Szerepi Gabor Kolus 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
1130 Edward Drive Great Falls, VA 22066 permit. Page 1 and 2 shr Department of Health an Important: If item 27 is any injury or other trau 1130 Edward Drive Edmond Fekecs Husband Baltimore. 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State 03/15/2012 Chestnut Grove Cem. Herndon, VA 4 Donation 5 Other (Specify) Signature of Funeral Service License 721 Elden St. 22. Name and Address of Facility hm Herndon, VA 20170 Adams-Green Funeral Home Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 23a. Part 1. Enter the diseas Approximate Interval Between Significant Death Immediate Cause (Final OVARIAN CARCINOMA Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, Examine Due to lor as a consequence of cause. Enter Underlying Cause (Disease or injury the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): physician Physician/Medical IF FEMALE asn 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant Ectopic pregnancy in the past 12 months? for (Month 5 Other (specify) Pregnant at time of death 1 Yes 2 9 I Inknown Ö Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown Records, director, page 2 should 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy perform Hospital or Attending Physician: The 1 ☐ Yes 2 ☐ No Yes 25. Was case referred to medical examiner? Division of Vital Be 26. Place of Death (Check only one) 1 ☐ Yes 2 🗙 No မ 1 Nnpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) filled in by the funeral 27. Manner of Death 28b. Time of 28c. Injury at work? 1 Yes 2 No Certificate: 28d. Describe how injury occurred 5 Pending injury Accide*n*t Investigation 24 hours after deat Funeral Director: 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical pertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check within 2 To the I the only one) 29d. Date signed (Month, Day, Year)
MANCH 9, 2012 0 Name and address of person who completed cause of death (Item 23a) (Type, Print) 6 420 LOCKIEDGE DR. BETTESDA, MD 20817 PRIEGO MD

DHMH 17 Rev 06-2011

State

Registrar

2000

Ś

7

8

3

gabriella

به

32. Registrar's agnature

2012

20

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death Physician/ February 2012 10:47 Naomi J. Ginyard Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Prince George's Clinton 5821 Barnes Drive 9. Birthplace (State or Foreign Social Security Number If Under Year If Under 24 Hrs. 8. Date of Birth 7. Age (In vrs. last birthday) **Funeral** 1 □ M 2 🔀 F April 24, Months Days Hours Min. Year) North Carolina 1933 Director 78 578-44-7992 Usual Residence of Decedent items 23a or 28a-f shov ier must be notified at 10b. County 10d. Inside City Limits permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho 10a. State 10c, City, Town or Location Director 1 X Yes 2 No Clinton Maryland | Prince George's 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral 20735 United States 5821 Barnes Drive 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces? Black, White, etc. 1 Never Married 2 Married þ Specify: Black Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 A No Specify: 3 X Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Government Department of Navy 12th Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Pauline Diggs Garland McIntyre 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 4304 Russell Avenue #4 Mount Rainier, Maryland Christina Craft - Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Marchate 6. 1 Burial 2 \square Cremation 3 \square Removal from State 4 \square Donation 5 \square Other (Specify) cemetery, crematory or other place) 2012 Landover, Maryland Harmony Inc. 22. Name and Address of Facility Stewart Funeral Home, 21. Signature of Funeral Service Lic Dan To 20019 Washington, DC 4001 Benning Road NE M00560 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final STROKE Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner BETES Sequentially list conditions, Examine Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events HYPERTENSION To the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of): resulting in death) Last HYPERLIPIDEMIA Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c, If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ Live Birth 2 Fetal death in the past 12 months? Month Day Pregnant at time of death Yes 2 No 9 Unknown signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ò 1 Yes 2 No 3 Probably 4 Unknown cate has been signated by page 2 should by Completed 24b. Were autopsy findings available 24a Was an autopsy prior to completion of cause of death? After this certificate | 1 Yes 2 No 2 1 director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 M Residence 6 Other (Specify) 2 No 1 Inpatient 2 ER/Outpatient 3 DOA ၉ within 24 hours after death.

To the Funeral Director: After this completed filled in by the funeral of 27. Manner of Death 28b. Time of 28a. Date of injury 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural (Month, Day, Year) 5 Pending 1 Yes 2 No Investigation 6 Could not be ☐ Accident ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifie 29d. Date signed (Month. Day, Year) MD

State

Registrar

6104 Old Branch Avenue

32. Registrar's Signature

Temple Hills, Maryland

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Hien T. Nguyen

6 2012

31. Date filed (Month, Day, Year)

		Ple - For	ease Type or P State of I							-		_	jible.		
	•	1 - State Registrar			Cen	tificate	of D	eath			Reg. N	o. 21	112	18	725
Physicia	in/	1. Decedent's Name (First, Midd								2. Date of De Month	eath Da	ay	Year	3. Time of E	
Medic	al	Eva Mae Goodm 4a. Facility Name (if not institution)		-)		4b City	Fown or	Location of	of Death	Feb_	05		2012 of Death	9:02	-AM
Examin	er	Fort Washingt	* *	,				hing				-	ce Ge	orge	
Funeral Director		5. Social Security Number 246–30–2148	6. Sex 1 □ M 2 🔀 F	Age (In yrs. I 94	ast birthday) Yrs.	If Under Months	1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of Bi		917_	9. Birthr Coun	olace (State or VC	Foreign
nd ihow at	ř	Usual Residence of Decedent 10a. State 10b. Count	ty	10c. Cit	ty, Town or Loc	ation							1	0d. Inside City	/ Limits
Maryla 18a-f etified	Director	MD Prin	ice George	Fo	ort Wash	ningt	on							1 🗌 Yes	2 X No
h the l ka or 2 be no		10e. Street and Number	. 7 1	"222		10f. Zip					10g. C	itizen of	What Cour	try?	
tth wit ms 23 must	Funeral	10850 Indian H	lead Highway		6 112.14	/as Deced	2074		ain? (Cn	ooify Von or No		44.5	USA		
er dez or ite miner	by Ft	11. Marital Status 1 ☐ Never Married 2 ☐ Married 2 ☐ Married 2	Armed Forces	3?	lf	Yes, spec	ify Cubar	, Mexican	ı, Puerto	ecify Yes or No Rican, etc.)		Blad	ce - Americ ck, White,	etc.	
ırs aft ural", ıl Exa		3 X Widowed 4 ☐ Divorce	If Von Cino		1	☐ Yes	2 X No	Specify:				Specify	Bla	ck	
72 hou	Completed		dent's Education hest grade completed)		16a. Decede	ind of wor	k done di		t of work	ing	16b. I	Kind of B	usiness Ind	dustry	
vithin pene.		Elementary/Seconday (0-12)) College (1-4 c	or 5+)		NOT use		ker			Ber	comar	ı Lau	ndry Co).
filed valued by all Hyg) Be	17. Father's Name (First, Middle	, Last)				Ī		er's Nam	ne (First, Middle					
uld be Ment narke	2	Quill Vinson			_			Nita	a Ri	ddick					
2 shouth and the and the strain trains		19a. Informant's Name/Relation Dawn Goodman/	grand-							al Route Numb #303,G					
1 and f Heal item other		20a. Method of Disposition			Place of Dispos	ition (Nan	e of			Date	i —		- City or To		
Page nent c ant: If ury or		1 X Burial 2 ☐ Crematio 4 ☐ Donation 5 ☐ Other		ilo	emetery, crem 1 Neck				Feb	13,2012	Co	omo,	NC		
permit. Page 1 and 2 should be filed within 72 hours after death with the Manyland Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Significatorist. If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		21. Signature of Funeral Service	Licensee		22.	Name an	Address	s of Facilit	У	neral H					
40 = # O		23a. Part 1. Enter the disease,	or complications that cause	sed the deat		518 W	est	Road	, Sa	lisbury	MI.	218	301	Approximate	
Physician/		shock, or heart failure. Lis Immediate Cause (Final	t only one cause on each	ine.	Do not onto		, or aying	, 00011 00	ou dido	or roop, atory a			Ì	Interval Betwo	een eath
Medical		disease or condition resulting in death)	a. Sepsi	as a consequ	uence of):								\dashv	ınknown	
Examiner	jr.	Sequentially list conditions,	b. —												
ed	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or iiniury	Due to (or a	as a consequ	uence of):										
executed in and ial-transit	_	that initiated events resulting in death) Last	c. Due to (or a	as a consequ	uence of):					G.L.					
ath certificate be ex attending physician for use as the buria	Physician/Medical		d												
certifica anding pl use as t	/Me	IF FEMALE:	23c. If <u>ye</u> s, outcor	ne of pregna	ancv										
eath ce attend for us	ician	23b. Was decedent pregnant in the past 12 months? 1 \sum Yes 2 \sum No	1 ☐ Live Birt 4 ☐ Pregnan	h 2 ∐ Feta tattime ofo	al death 3 📙	Ectopic p Other (sp		′					ite of delive onth	ery Day Ye	ar
that the dea	hys	9 Unknown	9 🗌 Unknow												
v requires that s been signed b should be det	by	Part II. Other significant condi	tions contributing to deat	n but not res	sulting in the ur	iderlying o	ause give	en in Part	l.					e cause of dea	
requir been s should	Completed									24a. Was				osy findings av	
sician: The law is certificate has k lirector, page 2 s	dwo									auto perf	opsy ormed?		prior to co death?	npletion of car	
ian: Th	Be C	25. Was case referred to medica examiner?	al				26. Pla	ce of Deat	th <i>(Ch</i> ec	1 □ Yes k only one)	2 🗷 N	lol	1 🗌 Yes	2 🖾 No	
hysici his ce al direc	으	1 Yes 2 No			ER/Outpatient			4 ∟ Nu	ursing Ho	ome 5 🗆 Res	idence (6 🗌 Oth	er (Specify)		
ding P h. After t funera	Certificate:	27. Manner of Death 1 Natural 5 Pend	all ig	njury Day, Year)	28b. Time of injury	M 2	3c. Injury work?			28d. Describe	how inju	ry occurr	ed		
Atten	rtific	3 ☐ Suicide 6 ☐ Coul	mined 28e. Place of I	njury - At ho	ome, farm, stre				140	28f. Location (er or Rural	Route Numbe	:T,
ital or irs afte al Din led in l			building,	etc. (Specify						City or To					
To the Hospital or Attending Physician: The law requires that the death certificate be exwithin 24 burus after death. within 24 burus after death. To the Funeral Director. After this certificate has been signed by the attending physician completed filled in by the funeral director, page 2 should be detached for use as the buria	Medical	(Check 2 L Medical	ng Physician: To the best I Examiner: On the basis of	f examinatio	n and/or investi	gation, in r	ny opinior	n, death oc	curred a	t the time, date	and place	e, and du	e to the cau	ıse(s) and manı	ner st <i>a</i> ted.
To the within To the comple	Σ	only one) 3 L Certifyii 29b. Signature and title of certifi	ng Nurse Practioner: To t ier	ne best of my	y knowledge, de		License		and plac	ce, and due to ti			anner as sta d (Month, L		
0 - 0		1 SA	V N	10		6	006	55	69	7		2	15,	2012	
7 8h		30. Name and address of person								/					
Stat		Dr. Tuan-Anh 31. Date filed (Month, Day, Year)	Vu, 11711 L	ivings	ston Ro	ad,]	ort	Wash	ingt	con, MD	207	44–5	164		
Registra		31. Date filed (Month, Day, Year)	2012 Pengu	NA	ure pav										

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 0°3°7 04 / 2°012 Margaret Evelyn Hoffman 9:00 PM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Cecil **Examiner** 207 Rowlandsville Road Conowingo 5. Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** Hours (Month, Day, Year) 214-38-8449 Director 1 □ M 2 💥 F 12/30/1917 94 Maryland Usual Residence of Decedent or 28a-f show notified at 10a. State 10c, City, Town or Location 10d. Inside City Limits with the Maryland Director 1 Tes 2 No Maryland Cecil Conowingo 10e. Street and Number 10f. Zip Code ö 10g. Citizen of What Country? United States of ms 23a or must be r Funeral 21918 207 Rowlandsville Road death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Examiner Black, White, etc. ō þ 1 Never Married 2 Married ☐ Yes 2 🔀 No permit. Page 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or any injury or other traumatic event, the Medical Examin Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: White Completed 3 X Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 8 Homemaker Home Be 17. Father's Name (First, Middle, Last 18. Mother's Name (First, Middle, Maiden Sumame) 2 John Trautfelter Margaret Buedel 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) K. Eileen Riedal (Daughter) 207 Rowlandsville Rd., Conowingo, MD 21918 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 Durial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 03/06/12 | West Chester, PA Signature of Funeral Service Licensee 22. Name and Address of Facility Zellman Funeral Home, P.A. 123 S.Washington St., Havre de Grace, MD Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ emio much disease or condition Medical resulting in death) **Examiner** 1 477 Sequentially list conditions Examine cause. Enter Underlying Hospital or Attending Physician; The law requires that the death certificate be executed Cause (Disease or injury that initiated events resulting in death) Last ent attending physician and for use as the burial-tran Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes No 5 Other (specify) Month Day Year Pregnant at time of death been signed by the sahould be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has autopsy performed? Yes 2 No 1 ☐ Yes 2 No After this certificate 25. Was case referred to medical funeral director, 26. Place of Death (Check only one) examiner? Other: 2 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home Residence 6 Other (Specify) Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28b. Time of 28d. Describe how injury occurred injury 5 Pending 24 hours after death. Funeral Director: A Accident Investigation the 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated within 24 hor To the Fune completely f Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 3 | only one)

State Registrar 29b. Signature and title of certifie

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

6405K

DHMH 17 Rev 06-2011

2

(a)

Registrar's Signatur

29c. License number

W. Machael L belti- MO 21014

29d. Date signed (Month, Day, Year)

12

			Pleas	e Type or Pri						_		_		
	•	For State Registrar		State of M	aryıan	•	tificate		lealth and I Death	vientai riy	giene Reg. N	001	2 0.8	727
Physicia	n/	1. Decedent's Name								2. Date of De	eath	1	3. Time o	
Medic	al			tchison, II			4h City	Town or	Location of Death	March		2012 Year	5:50) Ам
Examin		Cherry I	ane Nur	sing Center	5							Prince (3
Funeral Director		5. Social Security No. 177-40-7	7141	Sex 7. Ag 1 ☎ M 2 ☐ F	e (In yrs. Ia 62	st birthday) Yrs.	If Under Months	1 Year Days	If Under 24 Hrs. Hours Min.	8. Date of Bi (Month, Di July 1	rth ay, Year) 8, 1	9. Bi 949 Phi	rthplace (State o puntry) Ladelphia	
and show	or	Usual Residence of 10a. State	Decedent 10b. County		10c. City	, Town or Lo	cation						10d. Inside C	ity Limits
Maryk 28a-f	Director	Maryland		George's	La	ure1							1 🔀 Yes	2 🗆 No
vith the 23a or st be r	eral 🗅	10e. Street and Nun		e			10f. Zip		20708		10g. C	itizen of What C USA	ountry?	
permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	d by Funeral	11. Marital Status	ied 2 🛭 Married	12. Was Decedent Armed Forces?		1	Vas Deced f Yes, spec	ify Cubai	spanic Origin? (Sp n, Mexican, Puerto Specify:	pecify Yes or No Pican, etc.)	-	14. Race - Ame Black, Whit Specify: B	te, etc.	
2 hours "natur edical	Completed	(Spe	15. Decedent's			16a. Deced			ation luring most of work	kina	16b.	Kind of Business	Industry	
ithin 7	Com	Elementary/Second 12	onday (0-12)	College (1-4 or	5+)	life. D	O NOT use	retired)	grammer	3		IBM		
d be filed w Mental Hyg arked othe ttic event,	To Be	17. Father's Name (I		tchison, J	r.				18. Mother's Nan Yula Ler			Surname)		
nd 2 shoul ealth and I m 27 is ma er trauma		19a. Informant's Na Madhyatu		(Type, Print) cado / Nie	ce		_		nd Number or Ru gh Way, (
nt of H nt of H t: If iter			Cremation 3	Removal from State	C	lace of Dispo emetery, cren	natory or o	her place	- 1 3/9	Date / 2012		ocation - City o xandria		nia
mit. Pa bartme bortani / injury		4 L Donation 21. Signature of Fur	5 Other (Spe		Mai	rylano			nal : "	72012	1	39 Balt		
permi Depar Impo any ir		Ga	ylje	for Ro. gri					neral Hor		. Ну	attsvil	le, MD	20781
Physician/ Medical			rt failure. List only Final	mplications that cause one cause on each lin	e.		er the mode	of dying	g, such as cardiac	or respiratory a	rrest,	_	Approximate Interval Bet Onset and 3 Days	ween Death
Examiner				Due to (or as	,	,	ction	1						
p it	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): Multiple Sclerosis Due to (or as a consequence of):												
executed ian and irial-transit														
ite be e hysicia he bur	dical			d										
To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physicic completed filled in by the funeral director, page 2 should be detached for use as the bur	Physician/Medical	IF FEMALE: 23b. Was decedent in the past 12 r 1 Yes 2 G 9 Unknown	months?	23c. If yes, outcome 1 Live Birth 4 Pregnant a	2 Feta	death 3	Ectopic p		у			23d. Date of de Month	-	Year
res that the death signed by the atte d be detached for	by			contributing to death t	out not resi	ulting in the u	nderlying o	ause giv	en in Part I.			use contribute to		
require been si should	leted									24a. Was		24b. Were au	topsy findings	
The law ate has page 2 t	Completed								-	auto	psy ormed?	prior to death?	completion of c	
Physician: this certificaral director, programs	Be	25. Was case referre examiner?		Hospital:				Othe	ace of Death (Chec					
ng Phys fter this ineral dir	ite: To	1 ☐ Yes 2 ☑ 27. Manner of Death 1 ☒ Natural		1 Inpat 28a. Date of inju (Month, Da	ıry	ER/Outpatier 28b. Time of injury		Bc. Injury work	4 LX Nursing H	ome 5 Res 28d. Describe		6 Other (Sperry occurred	cify)	
Attendii death. ctor: A y the fu	Certificate:	2 Accident 3 Suicide	Investigati	be 200 Diago of Ini	urv - At ho	me. farm. stre	M eet. factory	1 🗆	Yes 2 ☐ No	28f Location (Street a	nd Number or Ru	ıral Boute Numb	oer.
tal or / irs after al Dire led in b		4 ∐ Homicide	determine	building, et	c. (Specify)	, , , , , , , , , , , , , , , , , , , ,				City or To				
To the Hospital or Attending Phyvithin 24 hours after death. To the Funeral Director: After the completed filled in by the funeral	Medical	(Check 2	Medical Exa	nysician: To the best of miner: On the basis of e urse Practioner: To the	xamination	and/or invest	tigation, in r	ny opinio	n, death occurred a	at the time, date	and plac	e, and due to the	cause(s) and ma	nner stated
Withi Com		29b. Signature and	title of certifier	R.		11 8	29c.		number			ate signed (Mont		
2		30. Name and addre	ess of nerson who	completed cause of c	leath (Item	23a) (Tivne F	2rint)	D2	24721			3/7/2012	<u>′</u>	
gi-		Syed Akl	oar Ali	Sadiq, M.D	., 14	333 La		Bow	ie Road,	#208, 1	Laur	e1, MD 2	20708	
Stat Registra		31. Date filed (Monti	h, Day, Year) 2012	32. Registr	ar's Signat	ure								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1 Decedent's Name (First Middle Last) 2. Date of Death Physician/ Month ^{Day} 2012 19:45 p M March 2 Delores Wilma Harris Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Prince George's Southern Maryland Hospital Clinton If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 6. Sex 8. Date of Birth (Month, Day, Year) 7. Age (In vrs. last birthday) **Funeral** Days Hours **Director** 1 □ M 2 🏲 F 578-70-7542 Dec. 19, 1934 Usual Residence of Decedent 28a-f show 10a. State 10b. County with the Maryland 10c. City, Town or Location 10d. Inside City Limits notified at Director 1 😾 Yes 2 🗌 No Maryland Prince George's Temple Hills ö 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? must be 23a Funeral 5313 Chesterfield Drive 20748 United States items death Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian Examiner Armed Forces? Black, White, etc. 9 þ 1 Never Married 2 Married Maryland 21215-0036 filed within 72 hours after If Yes, Give Year or Dates 1 Yes 2 No Specify: **Black** Specify: "natural" 3 Widowed 4 Divorced Completed Medical Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working Ith and Mental Hygiene. 27 is marked other than traumatic event, the Me life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Private 12th Homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Page 1 and 2 should be Sangie Pitts William Henry Adair 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20748it of Health a 5313 Chesterfield Drive Temple Hills, Maryland Nettie Thomas - Daughter other 3altimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State March^{Dat}10. 1 🗷 Burial 2 🗌 Cremation 3 🗀 Removal from State cemetery, crematory or other place) Department Important: If any injury or once, injury or 2012 Landover, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Harmony Signature of Funeral Service Licensee 22. Name and Address of Facility Stewart Funeral Home, John Stewar 7--20019 M00560 4001 Benning Road NE Washington, DC 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Ph_sician/ 664V disease or condition Medical resulting in death) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine Due to (or as a consequence of) the burial-transi Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical that the death certificate be P.O. Box 68760 use as IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) ___ in the past 12 months? Month Day Year Pregnant at time of death signed by the at d be detached for Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has performed? certificate 2 🗌 No 1 Yes al or Attending Physician: s after death. I Director: After this certific 25. Was case referred to medical funeral director, 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital 2 1 Yes 2 - No ER/Outpatient 3 DOA 1 Inpatient 2 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at 1 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide
4 Homicide Investigation completely filled in by the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined Hospital 24 hours Medical 29a. Certifier 🖵 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 2 [] 3 [] within 2 only one) Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

Registrar DHMH 17 Hov 06 2011

1

29b. Signature and title of certifier

1. Date filed (Month, Day, Year) NAR 0 7 2012

200

JOHEER

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

SAN FORMU

29c. License number

7503 Surratt

069

29d. Date signed (Month, Day, Year)

15

031 5

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Certificate of Death Reg. No. Registrar 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Day February Physician/ 0720M 20 John E. Halfhill Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (if not institution, give street and number) **Examiner** REGIONAL 100M100 PININSULA Mediene Cento 3 4 4 1 3 6 4 14 If Under 1 Year If Under 24 Hrs Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) Social Security Number '. Age (In yrs. last birthday) **Funeral** Hours **Director** 64 239-78-3200 1 🙀 M 2 🗆 F Yrs Dec. 29, 1947 North Carolina Usual Residence of Deceder 28a-f show 10d. Inside City Limits 10b. County 10c. City, Town or Location at 10a. State Director notified 1 ☐ Yes 2 🕱 No DE Sussex Delmar 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number ō must be items 23a Funeral 19940 U.S.A. 34628 Columbia Road death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 12. Was Decedent Ever in U.S. 11 Marital Status Armed Forces?

1 🔀 Yes 2 🗆 No 1966-Examiner Black, White, etc. ō 1 Never Married 2 X Married þ Maryland 21215-0036 1 Yes 2 X No Specify. Specify: "natural", white 3 Widowed 4 Divorced Completed Year or Dates 1970 the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry I Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) poultry company shop foreman 12 should be filed with and Mental Hygien is marked other to Be 18. Mother's Name (First, Middle, Maiden Surname, 17. Father's Name (First, Middle, Last) permit. Page 1 and 2 should be f Department of Health and Mental Important: If item 27 is marked any injury or other traumatic ev မ Effie V. Davis Emmett R. Halfhill 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Bernadette M. Halfhill (Wife) 34628 Columbia Road Delmar, DE Saltimore. 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 3-4-2012 Tyaskin, Maryland Tvaskin Cemetery 22. Name and Address of Facility
Short Funeral Home
13 East Grove Street 21. Signature of Funeral Service Licenses Delmar, DE 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Due to (or as a consequence of) disease or condition resulting in death) Medical **Examiner** 2 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Cause (Disease or injury that initiated events resulting in death) Last and Due to (or as a consequence of): attending physician Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 the as IF FFMALE yes, outcome of pregnancy
Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No ò Month Dav Year Other (specify) Pregnant at time of death signed by the at I be detached fo 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 3 ☑ Probably 4 ☐ Unknown 2 🗌 No 1 🗌 Yes Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy has performed?

Yes 2 No 1 🗌 Yes 2 🗌 No After this certificate funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital Other: 4 \square Nursing Home 5 \square Residence 6 \square Other (Specify) 2 1 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 횬 1 Yes 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Certificate: 1 Natural injury 5 Pending 1 ☐ Yes 2 ☐ No hours after death. Accident Investigation filled in by the 6 Could not be Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined within 24 hours a

To the Funeral [Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completely 3 only one 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie H71890 2012 29

310

State

Registrar

1665 Woodbrooke Dr. . 00 MAR 02 31. Date filed (Month, 2012

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar's Signature

D.0

21804

MD

Sal sbuny

VOID

CERTIFICATE

2012-08730

SEE

CERTIFICATE

2012-07078

Willie Jones

Completed 6-12-2012 U.S.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

		1 - State of Maryland / Department of Health and Mental Hyglene Certificate of Death Reg. No. 20 2 0 8 7 3											
=	Physicia	ın/	Decedent's Name (First, Middle, Last) IVYLINE		JOHN	ISON		2. Date of Deat Month	Day Y	3. Time of Death 23:15 PM			
D.	Medic Examin		4a. Facility Name (if not institution, give street a	nd number)	0011	4b. City, Town, or	Location of Death	MARCH	01 201: 4c. County of MONTG	Death			
anger of the	Funeral		HOLY CROSS HOSPITAL 5. Social Security Number 6. Sex	7. Age (In yrs. las	st birthday)	If Under 1 Year	SPRING If Under 24 Hrs.	8. Date of Birth		J. Birthplace (State or Foreign			
	Director		216-64-6235 1 □ M 2 Usual Residence of Decedent	X □ F 81	Yrs.	Months Days	Hours Min.	12-04-19		AMAICA, WI			
	yland -f show ed at	ctor	10a. State 10b. County MD PRINCE GEORG		Town or Loc	cation				10d. Inside City Limits 1 ✓ Yes 2 ✓ No			
	the Mar or 28a e notifi	Dire	10e. Street and Number	LAN	———	10f. Zip Code		1	10g. Citizen of Wha				
	th with ms 23a must b	Funeral Director	8607 CHERVIL RD.	- December 5 in 11.0	140.1	2070		anifu Van ar Na	USA				
9800	72 hours after death with the Maryland n "natural", or items 23a or 28a-f show fedical Examiner must be notified at		1 Never Married 2 Married 1	s Decedent Ever in U.S. ned Forces? ☑ Yes 2 X No es, Give ar or Dates.		Vas Decedent of Hi f Yes, specify Cubar ☐ Yes 2 🛣 No		Rican, etc.)		American Indian, White, etc. BLACK			
21215-0036	within 72 hour giene. rer than "natu t, the Medical	Completed by	15. Decedent's Education (Specify only highest grade com Elementary/Secondary (0-12) Col 1 2 TH	pleted) lege (1-4 or 5+)	(Give I life. D	lent's Usual Occupa kind of work done d O NOT use retired) AMSTRESS		ting	16b. Kind of Busin				
pue 2	filed valued Hyg	To Be	17. Father's Name (First, Middle, Last)	7D				ne (First, Middle, N	Maiden Surname)				
aryla	1 and 2 should be file of Health and Mental if item 27 is marked or other traumatic eve	_	I SREAL MILLI 19a. Informant's Name/Relationship (Type, Prin.		19b. Mailin	ng Address (Street a	MARY and Number or Rur	al Route Number,		e, Zip Code)			
e, M	and 2 s Health a tem 27 i		ARLENE PERELION 20a. Method of Disposition	20h Bi		CHERVIL sition (Name of		HAM, MD	20706 20c. Location - Ci	ty or Town State			
Baltimore, Maryland	Page 1		1 🔀 Burial 2 □ Cremation 3 □ Remov 4 □ Donation 5 □ Other (Specify)	-1 fram Chata Ce	meterv. cren	natory or other place LN CEMETI	e) ERY 3/10/	2012	BRENTWOO	DD, MARYLAND			
Balt	permit. Page Department of Important: If any injury or once,		21. Signature of Funeral Service Lice is e	LE	7	. Name and Addres	Y ST. NW	, WASHIN	GTON, DC	FUNERAL HOME 20011			
			shock, or heart failure. List only one caus	23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition STROKE)									
	Physician/ Medical Examiner		disease or condition resulting in death)	STROKE Due to (or as a conseque	ence of):								
		ner		Due to (or as a conseque	ence of):								
	and -transit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a conseque	ence of:		·						
200	cate be executed physician and s the burial-transit	ledical E	d	()									
	ertificat ding ph se as th		IF FEMALE: 23c. If y	es, outcome of pregnan	ncy				23d. Date	of delivery			
Вох	the death certific by the attending tached for use as	Physician/N	in the past 12 months?	Live Birth 2 Fetal Pregnant at time of de Unknown	death 3 [Ectopic pregnanc Other (specify)	у		Month				
s, P.O.	Attending Physician: The law requires that the dea card adding a card adding the this certificate has been signed by the set the funeral director, page 2 should be detached by the funeral director, page 2 should be detached		Part II. Other significant conditions contributi HYPERTENSION	ng to death but not resu	llting in the u	nderlying cause giv	en in Part I.			ute to the cause of death?			
cord	law requ has been je 2 shou	Completed by	DIABETES MELLITUS II					24a. Was a	sy pric	re autopsy findings available or to completion of cause of			
II Re	ician: The la certificate ha rector, page		25. Was case referred to medical			26 Pla	ace of Death (Chec	perform		ıth? ☑ Yes 2 ☐ No			
Vita	Physician: this certific al director,	To Be	examiner? 1 ☐ Yes 2 🛣 No	1 K Inpatient 2 □ E		nt 3 DOA Othe	er: 4 Nursing H		ence 6 🗌 Other (Specify)			
n of	nding P ath. : After t e funera	icate:	27. Manner of Death 28a 1 Natural 5 □ Pending 2 □ Accident Investigation	a. Date of injury (Month, Day, Year)	28b. Time of injury	work	rat ? Yes 2 □ No	28d. Describe ho	w injury occurred				
.≥	pital or Attending Ph burs after death. eral Director. After th filled in by the funeral	Certificate:	3 Suicide 6 Could not be 4 Homicide determined	. Place of Injury - At hor building, etc. (Specify)	ne, farm, stre	eet, factory, office		28f. Location (St City or Town		or Rural Route Number,			
	Hos Fun tely	Medical	29a. Certifier (Check only one) 29	the basis of examination	and/or invest	tigation, in my opinio	n, death occurred a	at the time, date an	d place, and due to	the cause(s) and manner stated.			
	To the I within 2 To the I comple	2	29b. Signature and title of certifier	(, mornings,	29c. License	number	2	gd. Date signed (/	Month, Day, Year)			
	5		30. Name and address of person who complete	ed cause of death (Item	234) (Type, F	D5669	91	<u>P</u>	MARCH 1,	2012			
	Act		1500 FOREST GLEN RD.	, SILVER SI	PRING,)						
	Sta Registr		31. Date filed (Month, Day, Year) NAR 0 7 2012	32. Registrar's Signatu									

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Day 2012 SARAH JAMES March 8:58 Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner 7015 Onyx Court Capitol Heights Prince George's 8. Date of Birth Jun. 25, 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) Funeral Hours 1 M 2 K F 1938 238-56-9104 73 Director Carolina North Usual Residence of Decedent 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Director r than "natural", or items 23a or 28a-f s the Medical Examiner must be notified Maryland| Prince George's Capitol Heights 1X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7015 Onyx Funeral Court 20743 USA Page 1 and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 African 1 Yes 2 X No Specify 3 Widowed 4 Divorced Completed American Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Housewife Private other traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Charles Farmer Virginia Outlaw 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is any injury or other trau Sandra Bulls (Daughter) Onyx Court, Capitol Heights, MD 20b. Place of Disposition (Name of cemetery, crematory or other proceedings of the Crematory Park 20a. Method of Disposition 20c. Location - City or Town, State 1 🗆 Burial 2 🖾 Cremation 3 🗆 Removal from State 03/06/2012 4 Donation 5 Other (Specify) Riverdale, Maryland 22. Name and Address of Facility Jordan Signature of Funera Funeral Service, Inc. Service Licenses 4001 Benning Rd., N.E., Washington, DC 20019 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Due to (or s a consequence of): Pnysician/ disease or condition resulting in death) neoplasu Medical Examiner Sequentially list conditions, Due to for as a consecuence of: cause. Enter Underlying Cause (Disease or iinjury as the burial-transi that initiated events Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical that the death certificate be Division of Vital Records, P.O. Box 68760 IF FFMALE nse 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No 3 Ectopic pregnancy Month Day Year Other (specify) Pregnant at time of death 5 1 Yes 2 9 Unknown ed by the a detached f 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ To the Hospital or Attending Physician: Telaw requires 1 Yes 2 No 3 Probably 4 Unknown een sig Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an p.ge2s has I autopsy Yes 2 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 No မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 X Residence 6 ☐ Other (Specify) After this completed filled in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending injury work?
1 Yes 2 No death. Accident Investigation within 24 hours after deat To the Funeral Director. 3 Suicide
4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Cartifying Nurse Practioner: To the bast of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29b. Signaty 29c. License number 29d. Date signed (Month, Day, Year)

Registrar

State

31. Date filed (Month, Day, Year

DHMH 17 Rev 7/2009

9200

who completed cause of death (Item 23a) (Type, Print)

AC000937

cras MB 20174

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year **Physician** 9:00 AM 2012 Keith A. Lipford March /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** SPECIAlty Baltimore MD 21230 HOSVITA If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, April 7, 9. Birthplace (State or Foreign Country) Maryland Social Security Number 6. Sex 7. Age (In yrs. last birthday, **Funeral** 1 ₹ M 2 ☐ F **Director** 218-76-5506 Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10d. Inside City Limits show item 27 is marked other then "naturel", or Items 23e or 28e-1 shov other treumatic event, the Madical Exx. Intel reset to rediffied at 1 ☐ Yes 2 ☑ No Director Ceci1 E1kton Maryland 10e. Street and Number 10f. Zin Code 10g. Citizen of What Country? 21921 United States 43 Johnstown Road death v Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black. White, etc. 1 □ Yes 2 → No If Yes, Give X Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 1 No Specify 3 Widowed 4 Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Truck Driver Trucking Department of Health and Montal Hyg Importent: If item 27 is marked other any injury or other treumatic event ones. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Frank Lipford Joan Walstrum 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Tina M. Lipford/Daughter 219 Howard Street, Elkton, MD 20b. Place of Disposition (Name of 20a. Method of Disposition 20c. Location - City or Town, State Cherry Hill Methodist Cemetery March 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Ponation 5 ☐ Other (Specify) 2012 Cherry Hill, MD ure of Funeral Service Licenses 22. Name and Address of Facility Hicks Home for Funerals, P.A. 21. Sign 103 W. Stockton Street, Elkton, MD 21921 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Sels] Physician disease or condition resulting in death) /Medical Due to (or as consequence of) **Examiner** hexia Shrowth Sequentially list conditions, if any, leading to immediate cause. Clisease or injury that initiated events use as the burial-tran resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760. the attending physician The law requires that the death certificate be Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal deal
4 Pregnant at time of death
9 Unknown 3 Ectopic pregnancy for in the past 12 months? Day Year 5 Other (specify) 1 ☐ Yes 2 ☐ No should be detached 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Anemia 1 Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy performe and Danwers Kidney 2 No 1 Yes 1 Yes funeral director, 25. Was case referred to medi al examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death

1 ☑ Natural

2 ☐ Accident 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 5 Pending investigation after death. 1 ☐ Yes 2 ☐ No the i 6 Could not be 3 ☐ Suicide Place of tnjury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a To the Funerel I Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29b. Signature and title of certifier no completed cause of death (Item 23a) (Type, Print) 6015. Charles St 32. Registra Signature State Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Physician Western Richard David McKenns An Earthyriae frame from Michael and Drive Richard David McKenns An Earthyriae frame from Michael and Business La Facting from for from the formation of the property of the formation of				1 - For State Registrar	State of M	1arylan		artment of I tificate of L		and M		giene Reg. No.	2012	08734
March 2, 2012 T.15 A or		Physicia	2/	1. Decedent's Name (First, Middle, I	•						2. Date of Dea	ath	Voor	3. Time of Death
Director Turner Director Control Cont		Medic	al			ia						2 <u>, 201</u>	2	7:15 A M
216-06-0299 TWM 12 15		Examin	er							of Death			,	
The control of the				216-60-6299			**						9. Birth F10	nplace (State or Foreign ntn) rida
David Edward McKenna/Son 1540 Main St. Ext Brogue, PA 17309 20a. Method of Dispetition 20a. Method of Dispetition 20a. Method of Dispetition 20a. Method of Dispetition 20b. Method of Dispetition 20b. Method of Dispetition 21c. Signar Specif Fuerral Specific Method of Spe		nd ihow at	or			10c. Cit	y, Town or Loc	cation					1	10d. Inside City Limits
David Edward McKenna/Son 1540 Main St. Ext Brogue, PA 17309 20a. Method of Dispetition 20a. Method of Dispetition 20a. Method of Dispetition 20a. Method of Dispetition 20b. Method of Dispetition 20b. Method of Dispetition 21c. Signar Specif Fuerral Specific Method of Spe		Maryla 28a-f s otified	irect		rundel	Edg	gewater							1 ☐ Yes 2 💢 No
David Edward McKenna/Son 1540 Main St. Ext Brogue, PA 17309 20a. Method of Dispetition 20a. Method of Dispetition 20a. Method of Dispetition 20a. Method of Dispetition 20b. Method of Dispetition 20b. Method of Dispetition 21c. Signar Specif Fuerral Specific Method of Spe		with the 23a or : ist be n	eral D		re		_							intry?
David Edward McKenna/Son 1540 Main St. Ext Brogue, PA 17309 20a. Method of Dispetition 20a. Method of Dispetition 20a. Method of Dispetition 20a. Method of Dispetition 20b. Method of Dispetition 20b. Method of Dispetition 21c. Signar Specif Fuerral Specific Method of Spe	36	ifter death ", or items aminer m	by	1 Never Married 2 Marrie	Armed Forces	2	If	Yes, specify Cuba	n, Mexica	n, Puerto l	cify Yes or No- Rican, etc.)		Black, White	, etc.
David Edward McKenna/Son 1540 Main St. Ext Brogue, PA 17309 20a. Method of Dispetition 20a. Method of Dispetition 20a. Method of Dispetition 20a. Method of Dispetition 20b. Method of Dispetition 20b. Method of Dispetition 21c. Signar Specif Fuerral Specific Method of Spe	0	hours a natural ical Ex	leted	15. Decedent	Year or Dates. s Education								WILL	
David Edward McKenna/Son 1540 Main St. Ext Brogue, PA 17309 20a. Method of Dispetition 20a. Method of Dispetition 20a. Method of Dispetition 20a. Method of Dispetition 20b. Method of Dispetition 20b. Method of Dispetition 21c. Signar Specif Fuerral Specific Method of Spe	1215	hin 72 ne. than "r	omo	Elementary/Seconday (0-12)		5+)	(Give k life. DC	ind of work done of NOT use retired)	during mos	st of worki	ng			
David Edward McKenna/Son 1540 Main St. Ext Brogue, PA 17309 20a. Method of Dispetition 20a. Method of Dispetition 20a. Method of Dispetition 20a. Method of Dispetition 20b. Method of Dispetition 20b. Method of Dispetition 21c. Signar Specif Fuerral Specific Method of Spe	<u>0</u>	led wit Hygie other ent, th	æ		t)		Truck	Driver	18. Moth	ner's Name	e (First, Middle,			ogistics_
David Edward McKenna/Son 1540 Main St. Ext Brogue, PA 17309 20a. Method of Dispetition 20a. Method of Dispetition 20a. Method of Dispetition 20a. Method of Dispetition 20b. Method of Dispetition 20b. Method of Dispetition 21c. Signar Specif Fuerral Specific Method of Spe	ylan	ild be fi Menta Iarked atic ev	မ				·		Etl	hel	Viola	Jenki	ns	
Comparison of Contraction	, Mar	d 2 shoualth and ration 27 is manualth											vn, State, Zip	Code)
23a. P.R. 1. Eiter the disease, or complies from that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Approximate interval Between shock, or heart failure. List only only fause on each line. Approximate interval Between operation of a season of the seas	nore			1 🗆 Burial 2 🗓 Cremation 3		e c	emetery, crem	natory or other plac	e)					
23a. P.R. 1. Eiter the disease, or complies from that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Approximate interval Between shock, or heart failure. List only only fause on each line. Approximate interval Between operation of a season of the seas	altir	ermit. Papartme spartme nportan ny injur				Kal			ss of Facil			Edgew. Kalas	Funer	MD al Home
Sequentially list conditions, cause friend access of consequence of): Due to (or as a consequence of): Due to (or as	11	20 E 20 1		///	V //	ed the deeth	29	73 Solom	ons]	<u>[slan</u>	d Rd. E	dgewa	ter, M	D 21037
The state of the s	4			shock, or heart failure. List onl Immediate Cause (Final disease or condition	y one lause on each lir	ne.			_	cardiac o	respiratory arr	est,		Interval Between Onset and Death
The state of the s	-				Due to (or as	a consequ	ience of):	iotle	Č					
Special Complete State Special Complete State Special Control Complete State Special Com		pe tis	miner	if any, leading to immediate cause. Enter Underlying										
FFEMALE: 23d. Date of delivery 23d. Date of deli		e executi ian and urial-trar	al Exa	that initiated events	C. Due to (or as	a consequ	ience of):							
FFEMALE: 23d. Date of delivery 23d. Date of deli	760	cate be physic s the bu	edica		d									
25. Was case referred to medical examiner? 26. Place of Death (Check only one) 27. Manner of Death 28. Date of injury 28. Date of injury 28. Date of injury 28. Injury at work? 1 Yes 2 No 28. Location (Street and Number or Rural Route Number, City or Town, State) 29. Day of the thorough of the cause(s) and manner as stated. 29. Signature and title of certifier 29. Signature and title of certifier 29. Signature and didfress of person who completed cause of death (Item 23a) (Type, Print) 20. Name and address of person who completed cause of death (Item 23a) (Type, Print)	89 ×	h certifi tending rr use a	ian/M	23b. Was decedent pregnant	1 Live Birth	2 🔲 Feta	l death 3	Ectopic pregnanc	;y			23d		
25. Was case referred to medical examiner? 26. Place of Death (Check only one) 27. Manner of Death 28. Date of injury 28. Date of injury 28. Date of injury 28. Injury at work? 1 Yes 2 No 28. Location (Street and Number or Rural Route Number, City or Town, State) 29. Day of the thorough of the cause(s) and manner as stated. 29. Signature and title of certifier 29. Signature and title of certifier 29. Signature and didfress of person who completed cause of death (Item 23a) (Type, Print) 20. Name and address of person who completed cause of death (Item 23a) (Type, Print)). Bo	the deat by the at ached fo	hysic	1 🗌 Yes 2 🗌 No			leath 5	Other (specify)					Month	Day Year
25. Was case referred to medical examiner? 26. Place of Death (Check only one) 27. Manner of Death 28. Date of injury 28. Date of injury 28. Date of injury 28. Injury at work? 1 Yes 2 No 28. Location (Street and Number or Rural Route Number, City or Town, State) 29. Day of the thorough of the cause(s) and manner as stated. 29. Signature and title of certifier 29. Signature and title of certifier 29. Signature and didfress of person who completed cause of death (Item 23a) (Type, Print) 20. Name and address of person who completed cause of death (Item 23a) (Type, Print)	JS, P.C	uires that n signed k ıld be det	by	Part II. Other significant conditions	contributing to death	but not res	ulting in the u	nderlying cause giv	en in Part	1.				•
25. Was case referred to medical examiner? 26. Place of Death (Check only one) 27. Manner of Death 28. Date of injury 28. Date of injury 28. Date of injury 28. Injury at work? 1 Yes 2 No 28. Location (Street and Number or Rural Route Number, City or Town, State) 29. Day of the thorough of the cause(s) and manner as stated. 29. Signature and title of certifier 29. Signature and title of certifier 29. Signature and didfress of person who completed cause of death (Item 23a) (Type, Print) 20. Name and address of person who completed cause of death (Item 23a) (Type, Print)	SCOR	law req has bee e 2 shou	mplet			_					autop	sy	prior to co	
27. Manner of Death 1	ž e	an: The tifficate tor, pag						26. PI	ace of Dea	ath (Check	1 Yes			2 🗌 No
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	7	hysici this cer al direc	은	1 Yes 2 No	1 Inpa			t 3 🗆 DOA Othe	er: 4 🗆 N			ence 6 🗆	Other (Specif	(y)
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	on o	anding F ath. r: After 1	icate:	1 Natural 5 Pending 2 Accident Investigat	ion (Month, Di	ury ay, Year)		work	?	_	28d. Describe h	ow injury oc	curred	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	DIVISI	al or Atters al al or Atters after de Il Directo			28e. Place of In			et, factory, office		1			mber or Rura	al Route Number,
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)		ne Hospit n 24 hour ne Funers oleted fille	Medica	(Check 2 Medical Exa	miner: On the basis of	examination	and/or investi	gation, in my opinio	n, death o	ccurred at	the time, date a	nd place, and	d due to the ca	ause(s) and manner stated.
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)		Northi COT			Im			29c. License	number			29d. Date si	gned (Month,	Day, Year)
State 31. Date filed (Mopth, Day, Xear) 2012 32 Registrar's Signature		10/19		30. Name and address of person wh	o completed cause of	death (Item	23a) (Type, Pr	rint)			un	2040	1	
)12 32 Regist	rar's Signat	ure de	a shad	- Ju	17 /	-//			

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ Year 42 A M 2012 WILLIE J. MILLINE SR Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death PRINCE GEORGE'S HOSPITAL CENTER PRINCE GEORGE'S CHEVERLY 8. Date of Birth (Month, Day, Year) March 5. 5. Social Security Number If Under Year If Under 24 Hrs 9. Birthplace (State or Foreign Funeral Days Months Min. 1 XM 2 □ F Hours Country) DC Director 578-66-4952 61 Usual Residence of Decedent or than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 No MD PG Landover 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 8514 Dunbar Ave 20785 US 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 Yes 2 X No Black, White, etc. 1 Never Married 2 X Married 5 Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 🔀 No Specify. **Black** Specify: 3 Divorced 4 Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit, Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than 'any injury or other traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) 12th Truck Driver Private 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Welton Milline Rose L. Clyde 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Dara Milline/ Wife 8514 Dunbar Ave, Landover, MD 20785 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 3/10/2012 Heritage Memorial Waldorf, MD 4 Donation 5 Other (Specify) Signature of Funeral Service Lic See 22. Name and Address of Facility Pope Funeral Homes, P.A. 5538 Marlboro Pike, Forestville, MD 20747 23a. Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. (ist only one cause on each line 5cr 43 Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner even Sequentially list conditions, it any leading to incredit cause. Enter Underlying Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and attending physician and for use as the burial-transit Cause (Disease or iinjury that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical HERADO NORM Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Pregnant at time of death 5 Other (specify) Yes 2 No 9 Unknown 9 Unknown is been signed by the should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an page 2 autopsy performed 1 Yes 2 No Yes 2 No 25. Was case referred to medical funeral director, Be 26. Place of Death (Check only one) examiner? Hospital Other: 1 Yes 2 7 No ဂ္ 1 Impatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury 28b. Time of Certificate: 28c. Injury at work? 28d. Describe how injury occurred 1 Natural (Month, Day, Year) 5 Pending 2 Accident
3 Suicide
4 Homicide 1 Yes 2 No Investigation the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number, City or Town, State) completed filled in by determined building, etc. (Specify) Medical 👱 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier D 2012 person who completed cause of death (Item 23a) (Type, Print)

State Registrar 31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend 1 per phy. 17 per fb. g926 4-20-12 sm. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 2012 Physician/ March 4. 4:30 A Antonio Sancho Martinez Edwuardo Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Prince George's Clinton Southern Maryland Hospital Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 6. Sex 8. Date of Birth 7. Age (In vrs. last birthday) **Funeral** Days Hours Min (Month, Day, Year) Director 225-87-0356 1 🛚 M 2 🗆 F Chile 11/26/1956 55 28a-f shov 10b. County 10c. City, Town or Location 10d. Inside City Limits Examiner must be notified at Director Prince George's Oxon HI11 1 Yes 2 X No Marvland 10e. Street and Number ö 10f. Zip Code 10g. Citizen of What Country? Funeral items 23a Chile 20745 5627 Helmont Drive 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 0 1XXNever Married 2 Married Completed by 1 ☐ Yes 2 🔀 🗖 of If Yes, Give Baltimore, Maryland 21215-0036 be filed within 72 hours after 1 X Yes 2 No Specify: "natural", Specify: 3 Divorced 4 Divorced Chilean Hispanic Year or Dates Page 1 and 2 should be filed within 72 hours ment of Health and Mental Hygiene. fant. If item 27 is marked other than "natur ury or other traumatic event, the Medical I ury or other traumatic event, the Medical I 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Non Profit 6+ Civil Engineer Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Juaquin Sancho Pinilla Joaquin Eduardo Sancho Martinez Cecilia Martinez Fernandez 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Edwin Cruz / Friend Helmont Drive Oxon Hill. MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State permit. Page 1 a
Department of IImportant: If ite
any injury or ot 1 ☐ Burial 2 🔀 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Kalas 3/6/2012 Crematory Edgewater, Maryland 21. Signat Funeral Service Licensee 22. Name and Address of Facility George P. Kalas Funeral Home PA 6160 Oxon Hill Rd. Öxon Hill, Maryland 20745 23a. PM 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner TROINTESTIN Sequentially list conditions Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last To the Hospital or Attending Physician: The law requires that the death certificate be executed PIRATURY Due to (or as a consequence of Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year 4 ☐ Pregnant at time of death 9 ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy death? perform 2 No 1 🗌 Yes Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 2 ၉ 1 Yes 1 Ninpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) Date of injury (Month, Day, Year) Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred work? 1 ☐ Yes 2 ☐ No injury Natural 5 Pending n 24 hours after deau...
he Funeral Director: Aft Investigation 2 Accident
3 Suicide
4 Homicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated completely Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated within 2 only one) who completed cause ath (Item 23a) (Type, Print) INTON MA 1503 State Registrar

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene = State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Day 1958 P.M Tomas Lumbres Natividad Medical 2012 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Montgamery Casey House Montgomery Hospice Rockville 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** Hours Months (Month, Day, Year) **Director** 575-55-6808 1 ▼ M 2 □ F 90 Usual Residence of Decedent 1921 Phippines 28a-f shov 10a. State 10b. County 10c. City, Town or Location or items 23a or 28a-f sho miner must be notified at 10d. Inside City Limits Director Type Yes 2 No Montgomery Rockville Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20853 14503 Bauer Dr Page 1 and 2 should be filed within 72 hours after death Was Decedent Ever in LLS Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, "natural", or iten edical Exaπiner r 11. Marital Status Armed Forces?

1 Yes 2 No Black, White, etc ģ 1 Never Married 2 Married Maryland 21215-0036 If Yes Give 1 ☐ Yes 2 No Specify 3 Widowed 4 Divorced Completed Year or Dates Filipino the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Agriculture Farmer 6 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) nd Mental F မ of Health and Menta if item 27 is marked r other traumatic er Juan Natividad Felomina Lumbres 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) if item 27 i Christy Natividad (Granddaughter) 12504 Rosebud Dr. Rockville, MD 20853 altimore, 20b. Place of Disposition (Name of cemetery, crematory or other place, 20a. Method of Disposition 20c. Location - City or Town, State XBurial 2 Cremation 3 Removal from State ò Department Important: If any injury or 4 ☐ Donation 5 ☐ Other (Specify) Tanauan Heritage Gardens 3/12/2012 Tanauan City, Batangas Signatur Funeral Service Licensee 22. Name and Address of Facility Rendon/Hale Funeral Home 9013 Annapolis Rd. Lanham, MD 20706 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph_sician/ Ischemic Cardiamyopathy disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** HIN Sequentially list conditions, if any, leading to immediate causa. Enter Underlying Cause (Disease or injury Examiner Due to (or as a consequence of) that initiated events Due to (or as a consequence of) resulting in death) Last the attending physician Physician/Medical death certificate be Box 68760 as the l IF FEMALE asn 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy for in the past 12 months?

1 Yes 2 No Month Day Year Pregnant at time of death Other (specify) be detached 1 L Yes 2 L 9 Dunknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by X Unknown Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 peen 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 ☒ No 24a Was an autopsy performed? Yes 2 X After this certificate has To the Hospital or Attending Physician: The li within 24 hours after death.

To the Funeral Director: After this certificate h. 25. Was case referred to medical examiner?
1 ☐ Yes 2 ▼ No Division of Vital filled in by the funeral director, Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 X Other (Specify) Hospice ည 2 X No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 1 □ Yes 2 □ No Certificate: 28d. Describe how injury occurred 1X Natural 5 Pending iniury 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practitioner. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year)

Registrar

DHMH 17 Rev 06-2011

1355 Picard Dr. Suite 100

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

G. Coleman MD

Date filed (Month, Day, Year)

D37142

Rockville, MD 20850

March 5, 2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death Physician/ Month Margaret Rollins 02/2972012 07:50 A M Medical 4a. Facility Name (if not Institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Prince Georges 2519 Newglen Ave District Heights **Funeral** 7. Age (In yrs. last birthday, 8. Date of Birth Birthplace (State or Foreign Country) 1 □ M 2 😿 F Days Hours 09/22/1927 **Director** <u> 224-32-8323</u> 84 Usual Residence of Decedent 28a-f shov 10a. State the Maryland notified at 10c. City, Town or Location 10d. Inside City Limits Director MD Prince Georges Suitland 1X Yes 2 ☐ No 10e. Street and Number ŏ 10f. Zip Code items 23a or ner must be n 10g. Citizen of What Country? Funeral 4305 Skyline Dr. 20746 with AZU filed within 72 hours after death 12. Was Decedent Ever in U.S Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, the Medical Examiner Armed Forces Black, White, etc ò þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Yes 2 X No 1 ☐ Yes 2 X No Specify. White Specify: Completed 3 X Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b, Kind of Business Industry (Specify only highest grade completed) Give kind of work done during most of working l Hygiene. other than ' life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 75 Federal Government Secretary Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) th and Mental F 27 is marked of traumatic even မ Page 1 and 2 should be Grover Cleveland Richardson Betsv Howard 19a. Informant's Name/Relationship (Type, Print) Department of Health as Important: If item 27 is any injury or other trau Marcello Rollando / son 4305 Skyline Dr., Suitland, MD 20746 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State MD Veterans Cemetery 03/07/2012 Cheltenham, MD 4 Donation 5 Other 22. Name and Address of Facility Strickland Funeral Services Signa vice 6500 Allentown Rd., Camp Springs, MD 20748 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Atherosclerotic Cardiovascular disease Ph_{sician/} disease or condition years Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of): Exami attending physician and for use as the burial-tran Due to (or as a consequence of) resulting in death) Last Physician/Medical or Attending Physician: The law requires that the death certificate be P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? 1 ☐ Yes 2 🔀 No sate has been signed by the atte page 2 should be detached for Month Dav Pregnant at time of death 1 ☐ Yes 2 12 9 ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? ò Division of Vital Records, Completed 1 Yes 2 ☐ No 3 ☐ Probably 4 🛛 Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy perform 1 Yes funeral director, To Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 X Other (Specify, Caregiver 2 X No 1 Inpatient 2 ER/Outpatient 3 DOA this Certificate: s after death. 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred X Natural 5 Pending 1 ☐ Yes 2 ☐ No Investigation 6 Could not be Accident filled in by the 3 Suicide 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) To the Hospital o within 24 hours af To the Funeral Di Medical 1 X Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier соmpleted

DHMH 17 Rev 7/2009

State

Registrar

29b. Signature and title of

M.

Ryan₁

30. Name an

<u> Erank</u> 31. Date filed (Month, Day, erson who completed cause of death (Item 23a) (Type, Print)

32. Regist ar's Sign

3 🗌 Certifying varse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

D19431

11701 Livingston Rd., apt. 103, Ft. Washington, MD 20744

29d. Date signed (Month, Day, Year)

03/05/2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Ethel Divine: Rawlings 3. Time of Death 2 ^{Day} Physician/ Month 02 2012 1638pM Medical 4c. County of Death
Prince Georges Facility Name (if not institution, give street and number)
Prince Georges Hospital 4b. City, Town, or Location of Death Examiner Center Cheverly If Under 1 Year I If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Social Security Number 247-64-3634 **Funeral** Days Hours 71 04722/1940 Bowman, SC **Director** 1 🗆 M 2 🔀 23a or 28a-f shov 10a. State 10d. Inside City Limits 72 hours after death with the Maryland traumatic event, the Medical Examiner must be notified at LOC. City, Town or Location Washington Director 1 X Yes 2 □ No 10g. Citizen of What Country? 10f **2**00 de 9 58th St. NE Funeral items ; Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Force Black, White, etc. 1 Never Married 2 Married ò þ Yes 2 X No Maryland 21215-0036 Specify: Black 1 Yes 2 No Specify: If Yes, Give and Mental Hygiene. is marked other than "natural", 3 XWidowed 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) 10th College (1-4 or 5+) Private Domestic Worker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname)
Corine Mallard 0 Silas Littles 19a. Informant's Name/Relationship (Type, Print)

Cora Lee Littles 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
12604 Lagrange Ct. Ft. Washington, DC 2074 permit. Page 1 and 2 sh Department of Health a Important: If item 27 is any injury or other tra Baltimore, 20a. Method of Disposition

1 Burial 2 Cremation 3 Removal from State 20c. Location - City or Town, State 20b. Place of Disposition (Name of Date cemetery, crematory or other place)
The Old Place Santee, 3/10/12 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee Dunn & Sons-5635 Eads St. NE WBShingstop 388 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, Examine any, leading to minediate cause. Enter Underlying Cause (Disease or injury that initiated events ng physician and as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE ttendi iç or use a 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No Day Month Pregnant at time of death g Unknow Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy death? certificate 2 No Yes Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital 2 🗶 No Other: ည 1 Yes npatient ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) After this Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: Natural work?
1 Yes 2 No injury 5 Pending Accident Investigation the Funeral Director: . 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined 24 hours a Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier *Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check within 2 To the I Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date signed Month, Day, Ye 29c. License number erson who completed cause of death (Item 23a) (Type, Print)

State Registrar 32. Registra s Signat

V-5613062 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death I. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician/ JOYCE IRENE ROLAND naich Medical Facility Name (if not institution ocation of Death ount of Death **Examiner** give street and number Social Security Number irthday) If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Hours Min. (Month, Day, Year) 216-40-9707 **Director** 1 M 2 SF 67 AUG.30,1944 WASH., DC 10b. County State 10c. City, Town or Location 10d. Inside City Limits notified at Director MD CHARLES WALDORF 28a-f 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? must be Funeral CONISTON COURT 20602 U. S. A. items ! 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Examiner Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates. Black, White, etc. 1 Never Married 2 Married ō þ 21215-0036 1 Yes 2 No Specify: Specify: "natural", 3 🗌 Widowed 4 🗌 Divorced WHITE Completed the Medical 15. Decedent's Education (Specify only highest grade completed) Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry than, Elementary/Secondary (0-12) College (1-4 or 5+) HOMEMAKER AT HOME other Be Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental F is marked o 2 pe 1 THOMAS AUBREY SHIPP Important: If item 27 is marke any injury or other traumatic ANNIE FRANCES ROACH e 1 and 2 should of Health and Me 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) LESLIE ROLAND / SPOUSE CONISTON CT., WALDORF, MD 20602 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date crematory or other place Burial 2 Cremation 3 Removal from State TRINITY MEM. GRDNS MAR. 15, 12 4 ☐ Donation 5 ☐ Other (Specify) WALDORF, MARYLAND 22. Name and Address of Facility RAYMOND FUNL. SERVICE, P.A. 21. Signature of Funeral Servi M00641 5635 WASHINGTON AVE., LA PLATA, MD 20646 23a Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Sepsis Immediate Cause (Final Physician/ Levere disease or condition 0 Medical resulting in death) Intection Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Sel Cause (Disease or injury that initiated events resulting in death) Last and for use as the burial-tran Due to (or as a consequence of) attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 nonths? No Month the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 Yes 2 No 3 Probably 4 Unknown Completed refet Intra Vanuely 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 4a. Was an autopsy page 2 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital 1 Yes 2 No ဂ္ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) . Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred

or Attending Physician: The law requires that the death certificate be executed this certificate has filled in by the funeral director, within 24 hours after death

To the Funeral Director: Hospital

Medical

6 gm

who completed cause of death (Item 23a) (Type, Print)

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

1970n

1 Yes 2 No

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29d. Date signed (Month, Day, Year) 03/09/2012

walder find.

28f. Location (Street and Number or Rural Route Number, City or Town, State)

6:

1 Yes 2XXIo

Onset and Death

Day

Year

30. Name and address of person

old Washi

Registrar

Natural

3 ☐ Suicide 4 ☐ Homicide

29a. Certifier

Accident

29b. Signature and title of

3 🗆

5 \square Pending

Investigation

determined

6 Could not be

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ March Elizabeth T. Slikker 2012 6:24 AM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Annapolis Anne Arundel Medical Center Anne Arundel Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) <u>Funeral</u> 8 Date of Birth Hours **Director** 237-34-4522 1 M 2 X F 87 Yrs. March 3. 1925 CA 28a-f shov 10a. State 10h County 10c. City, Town or Location 10d. Inside City Limits must be notified at Director MD 1 Yes 2 X No Anne Arundel Severna Park 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? nem z/ is marked other than "natural", or items 23a other traumatic event, the Medical Examiner must b Funeral 107 Wiltshire Ln 21146 USA 11. Marital Status 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc þ 1 Never Married 2 Married Yes 2 No Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: Specify: White 3 Widowed 4 🙀 Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. College (1-4 or 5+) 5+ Elementary/Secondary (0-12) Legislative Aide Anne Arundel County Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ပ John Lee Taylor Ruth E. Albright 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) f Health Betsy Slikker / Daughter Page 1 and 2 8211 Elvaton Dr., Pasadena, MD 21122 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Department of H Important: If ite any injury or otl once. 1 Burial 2 X Cremation 3 Removal from State 5 Other (Specify) 3/5/2012 4 Donation Kalas Edgewater, MD Crematory 21. Signature of uneral Service Licensee 22. Name and Address of Facility George P. Kalas Funeral Home 2973 Solomons Island Rd., Edgewater, MD 21037 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition Onset and Death Backeremi Ph_sician/ Medical resulting in death) Examiner ncy to penia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Exami phocyti lymphono Cause (Disease or injury that initiated events the burial-transi Due to (or as a consequence of) resulting in death) Last attending physician Physician/Medical certificate be Division of Vital Records, P.O. Box 68760 as IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) signed by the atter in the past 1: onths? Pregnant at time of death 2 No g Unknown 9 Unknowr Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacoo use contribute to the cause of death? þ 1 Yes 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an within 24 hours after death.

To the Funeral Director: After this certificate has completely filled in with the terminal process. autopsy 1 Yes 2 No Yes pletely filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital 1 Tes 2 [ပ Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) Date of injury (Month, Day, Year) Manner of Deat 28b. Time of Certificate: 1 Natural 28c. Injury at work? 28d. Describe how injury occurred 5 Pending Accident 1 Yes 2 No Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier crifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier

Registrar
DHMH 17 Rev 06-2011

State

elner wen

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

RV Kucy

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last 2. Date of Death 3. Time of Death Physician/ John Vincent Suit 12:20 PM February 2012 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Prince George's 4814 Blackfoot Road College Park Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) 8. Date of Birth **Funeral** Day, Hours Min. 1 🔀 M 2 🗆 F 217-88-5433 51 Cheverly, Maryland Director October 1960 Usual Residence of Decedent 28a-f shov "natural", or items 23a or 28a-f sho edical Examiner must be notified at 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Maryland Prince George's College Park 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20740 4814 Blackfoot Road USA death \ 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces Black, White, etc. ģ 1 Never Married 2 Married ☐ Yes 2 🛛 No Maryland 21215-0036 hours after If Yes, Give Year or Dates 1 Yes 2 No Specify Specify: White 3 Widowed 4 Divorced Completed the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry within 72 h (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Verizon Building Engineer 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) should be file and Mental F Charles A. Suit, Jr. Diana Maynard other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important; If item 27 is any injury or other trau Lisa Duffy / Sister 8809 Paris Estates Court, Owings, MD 20736 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State 3/3/2012 Fort Lincoln Cemetery Brentwood, Maryland 4 Donation 5 Other (Specify) . Signature of Funeral Service Licensee 22. Name and Address of Facility 4739 Baltimore Avenue Gasch's Funeral Home, P.A. Hyattsville, MD 20781 KAn Ruger) Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Onset and Death Immediate Cause (Final Physician/ Coronary Artery Disease disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Opioid Dependence Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of that the death certificate be executed and Due to (or as a consequence of): resulting in death) Last attending physician a for use as the burial-Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 Fetal death 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months? Month Day Year Pregnant at time of death 2 No been signed by the should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by or Attending Physician: The law requires 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2: autopsy performed this certificate 1 Yes 2 No Yes 25. Was case referred to medica Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify, 2 No ပ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: within 24 hours after death.

To the Funeral Director: After completed filled in by the funer. Natural work? 5 Pending 1 Yes 2 No Investigation Could not be Accident 3 ☐ Suicide 4 ☐ Homicide Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined the Hospital Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 10

10

Registrar
DHMH 17 Rev 7/2009

State

Mohammad

tohammud

Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

7525

D48042.

Greenway

3/01/2012.

Cener Drive IT Greenbell MD

SUVI-UVUZI M.D.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ lien inda Medical County of Death **Examiner** roverly trince If Under 1 Year If Under 24 Hrs. Date of Birth 9. Birthplace (State or Foreign **Funeral** -0715 Massachusetts 1 🗆 M 2 🔯 **Director** 28a-f show ed other than "natural", or items 23a or 28a-f sho event, the Medical Examiner must be notified at 10c. City, Town or Location Director 1 Yes 2 No 10g. Citizen of What Country? Funeral 20712 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. 11. Marital Status 14. Bace - American Indian Armed Forces?

1 Yes 2 No Black, White, etc. 1 Never Married 2 Married ò Maryland 21215-0036 2 No Specify If Yes, Give 3 Widowed 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life DO NOT use retired)

ECCOPTION IS 15. Decedent's Education (Specify only highest grade completed, 16b. Kind of Business/Industry and Mental Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) Be 17. Father's Name (First, Middle, 18. Mother's Name (First, Middle, Maiden Surname) ည (SON) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, 19a Informant's Name/Relationship (Type, Print) Department of Health ar Important: If item 27 is any injury or other trau ullen Mass 01020 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Nam-City or Town. State 1 Burial 2 Cremation 3 Removal from State cemetery, crematory or other place nesapeake 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition Medical resulting in death) **Examiner** Sequentially list conditions, Examine Due to (or as a consequence of) if any, leading to immedicause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last burial-tran and Due to (or as a consequence of): the attending physician Physician/Medical certificate be Box 68760 as the IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death asn 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 menths? ò To the Hospital or Attending Physician: The law requires that the death Month Day Year 9 Unknown P.O. I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 🗌 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy perform within 24 hours after death.

To the Funeral Director: After this certificate I completely filled in how the completely filled in how the 2 🗌 No 1 🗌 Yes 25. Was case referred to medica Be 26. Place of Death (Check only one) examiner? ၀ ☐ Inpatient 2 1 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c, Injury at 28d. Describe how injury occurred Natural 5 \square Pending work? Accident Investigation 3 Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and little of certifier 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) CHEVERIY. 3001 HOSPITAL DRIVE MD 31. Date filed (Month, Dav. Year State 7 2012 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			a FOI	partment of Health and M	1ental Hygie	ene						
1 - State Registrar Certificate of Death Reg. No. 2012												
	Physicia	n/	1. Decedent's Name (First, Middle, Last)		Date of Death Month	Day Year 3. Time of Death						
	Medic	al	James Edward Simmons		FEB.	27 2012 605 A M						
	Examin	er	4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Death						
	Comment		18306 Bubbling Spring Terr. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	Boyds) If Under 1 Year If Under 24 Hrs.	8. Date of Birth	Montgomery 9. Birthplace (State or Foreign						
	Funeral Director		242-68-2530 1 XM 2 F 68 Yrs.	Months Days Hours Min.	APR 23	(ear) 1943 North Carolina						
	W		Usual Residence of Decedent									
	yland •f shc ed at	ctor	10a. State 10b. County 10c. City, Town or L			10d. Inside City Limits 1 ☐ Yes 2 No						
	e Mar r 28a notifi	Oire	MD Montgomery Silver S	Spring 10f. Zip Code	10	g. Citizen of What Country?						
	ith th	Funeral Director	11649 Lockwood Dr.	' '								
	ath w	nue		20904 . Was Decedent of Hispanic Origin? (Spe	ecify Yes or No-	J.S.A 14. Race - American Indian,						
တ	er de or ite mine	by F	Armed Forces? 1 □ Never Married 2 □ Married 1 □ Yes 2♣ No	If Yes, specify Cuban, Mexican, Puerto	Rican, etc.)	Black, White, etc.						
8	ırsaft ural", IExa	pa	3 ☐ Widowed 4 ☒ Divorced If Yes, Give Year or Dates.	1 Yes 2 No Specify:		Specify: Black						
2	2 hou "natu edica	Completed	(Specify only highest grade completed) (Giv	edent's Usual Occupation e kind of work done during most of work	ing 1	6b. Kind of Business Industry						
12	thin 7)om		DO NOT use retired) eneral Contracto	or	Carpentry						
p	be filed within 72 hours after death with the Maryland ental Hygiene. ked other than "natural", or items 23a or 28a-f sho ked other than "hatural", or items 25a or 28a-f sho ic event, the Medical Examiner must be notified at	Be (17. Father's Name (First, Middle, Last)		e (First, Middle, Ma	iden Sumame)						
au	be fillental ked c	To	Joseph Simmons		Mae Park							
ary	1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at					Sity or Town, State, Zip Code) 20841						
Σ	2 ± 27		Cori Simmons- daughter 1830	06 Bubbling Spri	ing Terr	.,Boyds,Md.						
ore	of Hea of Hea fitem rothe		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 🗷 Removal from State 20b. Place of Disposition cemetery, or	oosition (Name of ematory or other place)	Date 2	0c. Location - City or Town, State						
Ĕ	Page 1 ment of tant: If it ury or o		4 Donation 5 Other (Specify)	Memorial 3/10)/2012 N	At. Airy,NC						
Baltimore, Maryland 21215-0036	permit. Page 1 Department of Important: If it any injury or c		21. Signature of Funeral Service Licens Steven L. Nabber MU1576	22. Name and Address of Facility Ete	ernal Fa	aith Funeral Svc.						
_			23a. Part 1. Enter the disease, or complications that daused the death. Do not ex			inkirk, Md. 20754						
			shock, or heart failure. List only one cause on each line.		,	t, Approximate Interval Between Onset and Death						
ion	Physician/ Medical		Immediate Cause (Final disease or condition resulting in death) Osteo Sara Due to (or as a consequence of):	sma		1 Jear						
	Examiner		Due to (or as a consequence of).									
		ner	Sequentially list conditions, if any, leading to immediate b. Due to (or as a consequence of):									
	uted d ansit	Examine	cause, Enter Underlying Cause (Disease or injury that initiated events c									
	te be executed nysician and he burial-transi	Ě	resulting in death) Last Due to (or as a consequence of):									
9	requires that the death certificate be executed been signed by the attending physician and should be detached for use as the burial-transit	dical	d	- · · · · · · · · · · · · · · · · · · ·								
387	ding b	Physician/Me	IF FEMALE: 23c. If yes, outcome of pregnancy			COd Date of delivery						
Box 687	ath ce attend for us	cian	in the past 12 months?	☐ Ectopic pregnancy ☐ Other (specify)		23d. Date of delivery Month Day Year						
m m	y the	hysi	1 Yes 2 No 9 Unknown	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,								
Division of Vital Records, P.O.	that the	by P	Part II. Other significant conditions contributing to death but not resulting in the		1 7	acco use contribute to the cause of death?						
S,	puires an sign uld be	ed k	Diabetes type I, Hyperten	sion, Hypercholest	1 □ Yes	s 2 No 3 Probably 4 Unknown						
Š	w rec as bee 2 sho	Completed			24a. Was an autopsy	24b. Were autopsy findings available prior to completion of cause of						
Rec	The la ate ha	Som			perform 1 Yes 2	ed? death?						
<u> </u>	crtific ertific	Be (25. Was case referred to medical examiner? Hospital:	26. Place of Death (Chec	k only one)							
<u> </u>	Physic this o	2	1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpat 27. Manner of Death 28a, Date of injury 28b, Time			ace 6 Other (Specify)						
0 0	ding Ing Ing Ing Ing Ing Ing Ing Ing Ing I	ate	1 Natural 5 Pending (Month, Day, Year) injury		28d. Describe how	7 Injury occurred						
Sio	Attender deat ctor:	Certificate:	2 Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, s		28f. Location (Stre	eet and Number or Rural Route Number,						
<u>∑</u>	al or Attending P s after death. I Director: After ti d in by the funera		4 Homicide determined building, etc. (Specify)		City or Town,	State)						
	To the Hospital or Attending Physician: The law requires that the death certifical within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending phycompleted filled in by the funeral director, page 2 should be detached for use as the	Medical	29a. Certifier	h occured at the time, date and place, ar	nd due to the cause	e(s) and manner as stated.						
	the He in 24 the Ft.	Mec	(Check Medical Examiner: On the basis of examination and/or inv	s, death sexumed at the time, data and plan	be, and due to the o	Eus (s) and manner as stated						
	Voit Tot		29b. Signature and title of certifier Sean S Saed	29c. License number		d. Date signed (Month, Day, Year)						
	24%	h	M	6 10-6035		March 7th, 2012						
	Ra		Sean S Soud 1120 Now 149 m 151	NE AVE #305	Silver CA	113, MD 20904						
	Sta	0	SECON S Saed 11120 Now May May 1131. Date filed (Month, Day, Year) 32. Registrary Signature	- 0 - 0010	1	1.41						
	Sta Registr		MAR 0 6 2012 Chan A Market M	RO 72012 Denne	p. 19. 19	ave.						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Voar Physician/ Kay S. Taylor 2012 Medical Facility Name (if not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death Examiner reamico 8. Date of Birth If Under 24 Hrs. Birthplace (State or Foreign Country) **Funeral** 6. Sex Age (In yrs. last birthday) Hours Min (Month, Day, Year) 213-24-0388 Director 1 M 2 X F Dec. 15, 1927 Maryland 84 Usual Residence of Decedent 10a. State 10h County 10c. City, Town or Location 10d. Inside City Limits must be notified at Director 28a-f Delmar 1 X Yes 2 No MD Wicomico 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? 5 23a Funeral 21875 U.S.A. 609 E. Walnut Street 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 🎛 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Examiner Black, White, etc. o 1 Never Married 2 Married Completed by トロッ しか しん Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 X No Specify. Specify: white "natural" 3 X Widowed 4 ☐ Divorced other traumatic event, the Medical 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Give kind of work done during most of working nd Mental Hygiene. life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) State Police police communications operator Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) and Mental H ဂ္ Cassie Dize George Riggin Stevenson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is any injury or other trau Mark A. Stephenson 8528 Gumboro Road Pittsville, MD 21850 (Executor) 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State 3-5-2012 Crisfield Cemetery Crisfield, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22, Name and Address of Facility
Short Funeral Home
13 East Grove Street Signature of Funeral Service Licensee Delmar, DE 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line. Onset and Death Immediate Cause (Final Physician/ HRONIC disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Examir attending physician and I for use as the burial-transit Cause (Disease or injury that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical or Attending Physician: The law requires that the death certificate be P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) in the past 12 menths? Month Day Year the a Pregnant at time of death 9 Unknown signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an ate has I perform 24 hours after death.
Funeral Director: After this certificate bearing and a second and a second and a second are bear after this certificate. 1 Yes filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Tot Other: 4 Nursing Home 5 Residence of Other (Specify) 405P1 43 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at work? Natural 5 Pending 1 Yes 2 No Accident Investigation 6 Could not be ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Hospital Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Gertifying Nurse Practitioner: To the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3. Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 To the F only one 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) 0

Registrar
DHMH 17 Rev 06-2011

State

173

Bup

v

Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

HarAM

31. Date filed (Month, Day, Year)

MAR

12-01576

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Hope S. Tarrance State of Maryland / Department of Health and Mental Hygiene 2012 08746 1- For State Certificate of Death Reg. No. Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Day February 23, 2012 **Medical Examiner** 0738 hrs Hope S. Tarrance 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death c. County of Death Peninsula Regional Medical Center Salisbury Wicomico 5. Social Security Number 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. **Funeral** Foreign Min Months Days Hours Director 217-57-0334 1___M 2 X F 4-7-2000 11 Usual Residence of Decedent 10c. City, Town or Location 10d, Inside City Limits 1 X Yes 2 No Baltimore, MD 21215-0036
permit. Pages I and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f ahow
injury or other traumatic event, the Medical Examiner must be notified at once. MD Wicomico Delmar Director 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code West Pine Street 21875 USA Funeral 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Armed Forces? 1 Never Married 2 Married Specify: Black 1 Yes 3 Widowed 4 Divorced If Yes, Give Year 1 Yes 2 X No specify: 2 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Completed Elementary/Secondary (0-12) College (1-4 or 5+) N/A17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) Be Eugene L. Tarrance Sylvia P. Briddell 19a. Informant's Name/Relationship (Type, Print) ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Eugene L. Tarrance/Father West Pine Street, Delmar, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State crematory or other place) 1 X Burial 2 Cremation 3 Removal from State Snow Hill Del Cem \$-2-2012 4 Donation 5 Other Specify: |Snow Hill, MD 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Bennie Smith Funeral Home 917 W. Isabella St. Salisbury, MD 21801 Physician 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval failure. List only one cause on each line. Between Onset and /Medical aX-Linked Creatine Transporter Deficiency with seizures Immediate Cause (Final disease or condition resulting in death) Examiner Due to (or as a consequence of) Sequentially list conditions, Due to (or as a consequence of): Examine if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last After this certificate has been signed by the attending physician and funeral director, page 2 should be detached for use as the burial - transi Physician/Medical AMENDED 23a, 27, per me, g927 5-24-12 sm X UNPENDED certificate be Box 68760, IF FEMALE 23d. Date of delivery 23c. If yes, outcome of pregnancy 3b. Was decedent pregnant in the 1 Live birth 2 Fetal death 3 Ectopic pregnancy Month Year Day past 12 months? 4 Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 V Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, P.O. ğ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available autopsy prior to completion of cause of performed death? Yes 2 No 1 🗸 Yes Hospital or Attending Physician: 25. Was case referred to medical 26.Place of Death (Check only one) Division of Vital å Other Nursing Home 5 Residence 6 Other: 1 Yes 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 X Natural 1 Yes 2 No Fuoeral Director: 5 Pending 2 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City 3 Suicide 6 Could not be or Town, State) determined Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 📝 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) one) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. February 24, 2012 30. Name and address of person who completed cause of death (Item 23a) Russell Alexander MD. Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223 31. Date filed (Month Day, Year) 2012 32. Registrar's Signature backe COME

Registrar

Leneur

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registra AMEND#20b per FH 03/7/12 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ March 1, 2012 0030 Hester Jane Thompson Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Takoma Park Montgomery Washington Adventist Hospital Social Security Number 7. Age (In vrs. last birthday) 1 Year If Under 24 Hrs. 8 Date of Birth Birthplace (State or Foreign Country) **Funeral** Min 578-22-8286 **Director** 1 🗆 M 2 🖾 F 1917 94 Usual Residence of Decedent 26. Maryland show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director notified 28a-f 1 T Ves 2 No Hyattsville Prince George's Maryland 10e. Street and Number 10f. Zip Code ō 10g. Citizen of What Country? ms 23a or must be i Funeral 20782 United States 5821 Queens Chapel Road Page 1 and 2 should be filed within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12 Was Decedent Ever in U.S. 14. Race - American Indian Examiner Armed Forces?

1 Yes 2 No Black, White, etc. ō þ 1 Never Married 2 Married Specify: African Baltimore, Maryland 21215-0036 1 Yes 2 No Specify. If Yes, Give Year or Dates Completed 3 X Widowed 4 Divorced American the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working than life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Private 12th Cook Department of Health and Mental Hygis Important: If item 27 is marked other any injury or other traumatic event, tl Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Daniel Cole Hattie Davis 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Angela Hassan - Daughter 3136 Cherry Road NE Washington, DC 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery crematory or other place)
Arlington
ational Cemetery 1 🖾 Burial 2 🗆 Cremation 3 🗆 Removal from State 3/13/2012 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Stewart Funeral Home, 21. Signature of Funeral Service Licensee tolic 4001 Benning Road NE Washington, DC M00560 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Physician disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) Cause (Disease or injury that initiated events resulting in death) Last iding physician and use as the burial-tran Due to (or as a consequence of): Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physicia Box 68760 use as IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Month Day Year Pregnant at time of death been signed by the s should be detached 1 | Yes 2 L P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 2 No 3 ☐ Probably 4 ☐ Unknown 1 🔲 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2 🗌 No 1 🗌 Yes Yes 2 funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 12 No Other: 흔 1 🗌 Yes I 🎢 Inpatient 2 □ ER/Outpatient 3 □ DOA 4 Nursing Home 5 Residence 6 Other (Specify) Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending Natural Accident work 1 Yes 2 No Investigation 3 Suicide 4 Homicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier completely 3 🗌 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signatufe and title of certifier 29d. Date signed Month, Day, Year)

Registrar

DHMH 17 Rev 06-2011

State

31. Date filed (Month, Day, Year)

address of person who completed cause of death (Item 23a) (Type, Print)

32. Regiatrar's Si

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 2012 Physician/ Robin Ann Whistler 1:33 \mathbf{P}^{M} March 3, Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Prince George's Hospital Prince George's Cheverly Social Security Number If Under 1 Year | If Under 24 Hrs. 6. Sex 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) **Funeral** Hours 212-88-2027 Director 1 🗆 M 2 🕱 F 51 August 24, 1960 Laurel, Maryland Usual Residence of Decedent 28a-f show 10b. County 10c. City, Town or Location "natural", or items 23a or 28a-f sho edical Examiner must be notified at 10d. Inside City Limits Director Prince George's Bladensburg 1 X Yes 2 No Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral filed within 72 hours after death with 20710 4231 58th Avenue, Apt. T-2 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Race - American Indian 0. Black, White, etc. 1 Never Married 2 Married þ ☐ Yes 2 🗵 No Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: If Yes, Give Completed 3 Widowed 4 Divorced Specify: White Year or Dates er than "natura;; the Medical E 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Retail Sales Salesperson 11 marked other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be f Department of Health and Menta Important: If item 27 is marked any injury or other traumatic ev 2 Frederick Matthew Thierauf Emily Jane Masenheimer 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Tina Marie Whistler / Daughter 4231 58th Avenue, Apt. T-2, Bladensburg, MD 20710 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 Burial 2 X Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metropolitan Crematory 3/7/2012 Alexandria, Virginia 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 4739 Baltimore Avenue Gasch's Funeral Home, P.A. Hyattsville, MD 20781 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph_sician/ FATAL CARDIAC disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of): cause. Enter Underlying Cause (Disease or injury that initiated events Exami Hospital or Attending Physician: The law requires that the death certificate be executed sician and burial-trans Due to (or as a consequence of): resulting in death) Last physician Physician/Medical Division of Vital Records, P.O. Box 68760 attending p IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Year Pregnant at time of death 5 Other (specify) Day 1 Yes 2 9 Unknow Unknown been signed by should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has performed Yes 2 After this certificate 1 🗌 Yes 2 No ours after death.

eral Director: After this certific filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 2 No Hospital: Other: 1 🗌 Yes မ R/Outpatient 3 DOA 1 Inpatient 2 4 Nursing Home 5 Residence 6 Other (Specify Manner of Death 28a. Date of injury Certificate: 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred (Month, Day, Year) Natural 5 Pending 1 Yes 2 🗌 No Accident Investigation Suicide 6 Could not be 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 24 hours Funeral Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier within 24 hor To the Fune completely f 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and til D70873 ss of person who completed cause of death (Item 23a) (Type, Print) 30. Name and addre CHEVELLY, MO 3001 HOSPITAL DR MCLESTER MD Date filed (Month, Day, Year

DHMH 17 Rev 06-2011

Registrar

2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			1 - State Amend Items 2 Registrar	State of Marylar 3aPtI,25 per 1	nd / Depa ne , g92 6 ne , g	artment of F 5,04/05/2 Thicate of L	lealth and I 012dhb Death	Mental Hygi Re	ene g. No. 2 N	12 08749
Ī	Physicia		1. Decedent's Name (First, Middle, Las Minnie	Weave:	r			2. Date of Death		3. Time of Death 7:32 p M
	Medic Examin		4a. Facility Name (if not institution, give	*			Location of Death		4c. County of	f Death
2000	Funeral		15704 Henri 578-30-3088 6. Se	etta Dr 7. Age (In yrs	ast birthday)	If Under 1 Year	cokeek If Under 24 Hrs.	8, Date of Birth		ce George 9. Birthplace (State or Foreign
	Director			□м жұт 93	Yrs.	Months Days	Hours Min.	Jan 19,1	919	South Carolina
	aryland a-f show fied at	ector	10a State 10b County Prince	George 10c. Cr	ty, Town or Lo	cation cokeek		'		10d. Inside City Limits 1 ☐ Yes 2 🛂 No
	with the Ms 23a or 28	Funeral Director	10e. Street and Number 15704 Henrietta	Dr		10f. Zip Code 2060	7	10	g. Citizen of Wh	nat Country?
21215-0036	s filed within 72 hours after death with the Maryland tal Hygiene. ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	Completed by Fur	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 🖾 Divorced	12. Was Decedent Ever in U. Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates.		Nas Decedent of Hi f Yes, specify Cubar I ☐ Yes 2XXNo	n, Mexican, Puerto	ecify Yes or No- Rican, etc.)		American Indian, White, etc. Black
15-(72 hou in "nat Medica	mple	15. Decedent's Ed (Specify only highest gra	de completed)	(Give i	dent's Usual Occupa kind of work done d	ation Juring most of work	ing 1	6b. Kind of Busi	iness/Industry
212	led within Hygiene. other thai		Elementary/Secondary (0-12) 6th	College (1-4 or 5+)	Dry	O NOT use retired) Cleaner			Ser	vices
Maryland	d be filed Mental H arked ot rtic even	To Be	17. Father's Name (First, Middle, Last)	navailable				e (First, Middle, Ma Mae Dod	well	
	of and 2 should be file of Health and Mental F fitem 27 is marked or rother traumatic even		19a. Informant's Name/Relationship (Ty Priscilla Nixon	pe, Print) (Daughter)	19b. Mailir 15	ng Address (Street a 5704 Henri	ind Number or Run ietta Dr	al Route Number, C Accokeek	City or Town, State	te, Zip Code) 07
Baltimore,	Page 1 and ment of He tant: If item ury or othe		20a. Method of Disposition 1XX Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify	Removal from State Ft	Lincol	sition (Name of natory or other place n Cemete)	ry 3./9/2	2012	Brentwo	
Balt	permit. Page Department of Important: If any injury or once,		21. native of Funeral Service Livens	umore	22	Name and Addres 818 E Bal	s of Facility Lat timore s	imore Fun t Baltimo	neral Se ore Md 2	ervice 21224
	cate be executed Medical Examiner the burial-transit	edical Examiner	23a. Part 1. Enter the disease, or comp shock, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. Due to (or as a consequence) kinson nce of): uence of):	's Diseas	e ons	PROVED W NEUCO		Approximate Interval Between Onset and Death	
. Box 68760	To the Hospital or Attending Physicián: The law requires that the death certificat within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending phy completely filled in by the funeral director, page 2 should be detached for use as the	≥	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 No 9 □ Unknown	23c. If yes, outcome of pregna 1 ☐ Live Birth 2 ☐ Feta 4 ☐ Pregnant at time of a	al death 3	Ectopic pregnancy			23d. Date Monti	The state of the s
ls, P.0	uires that the signed by all the detail	þ	Part II. Other significant conditions co	ontributing to death but not res	ulting in the u	nderlying cause give	en in Part I.			ute to the cause of death?
Division of Vital Records, P.O.	The law recate has bee page 2 sho	Completed						24a. Was an autopsy performs	prid	ere autopsy findings available or to completion of cause of ath? Yes 2 \sumbed No
ita	sicián: certific irector,	Be	25. Was case referred to medical examiner? 1 X Yes 2 No	Hospital:		Otho	ce of Death (Chec	k only one)		
on of V	To the Hospital or Attending Physicián: The law within 24 hours after death. To the Funeral Director. After this certificate has completely filled in by the funeral director, page 2.	icate: To	27. Manner of Death 1 Natural 5 Pending 2 Accident Investigation	1	ER/Outpatien 28b. Time of injury	28c. Injury	4 ☐ Nursing Ho	ome 5 Resident 28d. Describe how		(Specify)
Division	To the Hospital or Attending I within 24 hours after death. To the Funeral Director: After completely filled in by the funer	Il Certificate:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At ho building, etc. (Specify	ome, farm, stre	eet, factory, office		28f. Location (Stre City or Town,		or Rural Route Number,
	he Hospil in 24 hour he Funera pletely fill	Medical	(Check 2 Medical Examin	ician: To the best of my know ner: On the basis of examination	and/or invest	igation, in my oplnior	n, death occurred a	t the time, date and	place, and due to	the cause(s) and manner stated.
	To t		29b. Signature and fittle of certified	2 AMO	D.	29c. License	number	290	d. Date signed (/	Month, Day, Year)
			30. Name and address of person who co	ompleted cause of death (Item	23a) (Type, P	rint)	000 4	> M	lacch	4, 2012
	A-c	3,00	Melanie Rey. 31. Date filed (Month, Day, Year)	nolds ANR 32. Registrar's Signar	·BC	920	o Ba	sil Ct	Ste	2, 2012 200 Lorgo HD
	Stat Registra		MAR O 6 2012 Denne	a A pain						2017

Phy Ex Fun Dire permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		for State Registrar		state of	iviai yiai i	-	tificate of D			Reg. No. 2	2 08750
Physicia	an/	Decedent's Name (First, Michael Control of the							2. Date of De Month Februa:		3. Time of Death
Medi	cal	Dorothy 4a. Facility Name (if not institut					4b. City, Town, or	Location of Death		4c. County of De	
Exami	ner	Washington				1		oma Park		Montgor	
Funeral		5. Social Security Number	6. Sex		. Age (In yrs. la	ast birthd a y)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.		th 9. E	Birthplace (State or Foreign
Director		218-18-6216 Usual Residence of Decedent		1 2 3 3 1	86	Yrs.			June 1	y Year 1925 S	Maryland
and show dat	ρ	10a. State 10b. Cour	ity		10c. Cit	y, Town or Loc	ation				10d. Inside City Limits
Mary 28a-f otifie	irec	DC						Wash	ington		1 🔀 Yes 2 🗆 No
ith the	Funeral Director	10e. Street and Number 1312 Franklin	Ctroc	+ NE			10f. Zip Code	20017		10g. Citizen of What C	·
eath w	-un-	1312 FFARKIIII	12.	Was Deced	ent Ever in U.S	6. 13. W	/as Decedent of His Yes, specify Cubar		pecify Yes or No-	14. Race - An	nerican Indian,
after de l", or if	ρ	1 Never Married 2 N	Married	Armed Force 1 Yes 2 If Yes, Give	2 🔀 No		Yes, specify Cubar ☐ Yes 2 🌣 No		o Rican, etc.)	Specific Af	ijte, etc. E ric an
nours a	Completed	3 X Widowed 4 ☐ Divord	dent's Educa	Year or Date	es.	16a, Deced	ent's Usual Occupa	ation		Ame 1	cican se Industry
in 72 h e. nan "n	dwc	(Specify only his Elementary/Seconday (0-12		completed) College (1-4	or 5+)	(Give k	ind of work done do NOT use retired)	uring most of won	king		,
d with lygien ther th	Be C			4			Data An				ernment
be file ental F ked of c evel	PB PB	17. Father's Name (First, Middl	e, Last) roy Ni	chole	on				ne (First, Middle, ammie Ta	Maiden Surname)	
and Me		19a. Informant's Name/Relation			OII	19b. Mailin	g Address (Street a			er, City or Town, State, 2	Zip Code)
nd 2 sl ealth a nn 27 is ier tra		Diane Davis -	Daugh	nter		13300) Baltimo	re Ave	Laurel,	Maryland	20707
permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy rijury or other traumatic event, the Medical Examiner must be notified at once.		20a. Method of Disposition 1 🔼 Burial 2 🗆 Cremati		noval from S	State C	emetery, crem	sition (Name of atory or other place	i		20c. Location - City	
mit. Pa partmer portant injury		4 ☐ Donation 5 ☐ Other 21. Signature of Funeral Service		1 -] Ma		National Name and Address		2012 ewart Fu	Laurel, uneral Home	Maryland , Inc.
permit Depar Impor any ir		John T. 2	Heur	12	M0056					nington, DO	20019
		23a. Part 1. Enter the disease shock, or heart failure. Li Immediate Cause (Final	or complicat st only one ca	tions that ca ause on eacl	b.line.			, such as cardiac	or respiratory ar	rest,	Approximate Interval Between Onset and Death
Physician/ Medical	1	disease or condition resulting in death)	a	Due to (o	r as a consequ	ence of):	voc K				
Examiner		Sequentially list conditions	h .	Bill	a torou		piration	n (na	umor	ria	
od Sit	edical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury	2	-	ras a consequ Io mi	uence of):	Trin	ontre			
xecute n and al-trans	Exar	that initiated events resulting in death) Last	c		r as a consequ	ience of):		TOTA C			
icate be executed physician and s the burial-transit	lical		d								
		IF FEMALE:		16							
ath certifi attending for use as	cian,	23b. Was decedent pregnant in the past 12 months?		1 Live B	ome of pregna irth 2 Feta ant at time of c	ıl death 3 🗌	Ectopic pregnancy Other (specify)	y		23d. Date of o Month	delivery Day Year
the deal	hysi	1 Yes 2 No 9 Unknown		9 Unkno							
s that s	Be Completed by Physician/N	Part II. Other significant cond	itions contrib	outing to dea	ath but not res	ulting in the ur	nderlying cause give	en in Part I.		obacco use contribute	
equire een si	eted	Hym	+//	rus C	13/100		400	2/15	1 🗆		Probably 4 Unknown
e law r has b ge 2 sl	Jdw	- 1 1 pos	earles	(00	. 11 .				24a. Was auto perfo	psy prior to ormed? death'	autopsy findings available o completion of cause of ?
an: The tificate tor, pa	ပို	25. Was case referred to media	al	Cojn	a trug		26. Pla	ice of Death (Chec	1 \(\superset \text{Yes}\)	2 € No 1 4	′es 2 □ No
nysicia lis cer direct	To B	examiner? 1 Yes 2 No	Hosp	oital: 1 🗌 ir	npatient 2 🗷	ER/Outpatien	t 3 DOA Othe	r: 4 Nursing H	lome 5 Resi	dence 6 Other (Sp	ecify)
To the Hospital or Attending Physician: The law requires that the death certification 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending completed filled in by the funeral director, page 2 should be detached for use a	Certificate:	27. Manner of Death 1 Natural 5 Per	nding	28a. Date of (Month	f injury , <i>Day</i> , Ye <i>ar)</i>	28b. Time of injury	28c. Injury work? M 1 🗆 N	at ? Yes 2 \Begin{array}{l} No	28d. Describe l	now injury occurred	
Attender deat sector:	rtific	3 Suicide 6 Co	estigation uld not be ermined				et, factory, office	163 2 110		Street and Number or F	Rural Route Number,
tal or is afte al Dire					g, etc. (Specify				City or Tov		
Hospi 24 hou Funer eted fil	Medical	(Check 2 Medic	al Examiner:	On the basis	of examination	n and/or investi	igation, in my opinior	n, death occurred a	at the time, date a	ause(s) and manner as s and place, and due to th ne cause(s) and manner a	e cause(s) and manner stated.
To the To the Compl	Σ	only one) 3 L Certify 29b. Signature and title of cert		CONCINCT: IC	THE DEST OF IT	, Milowieuge, a	29c. License	number		29d. Date signed (Mor	nth, Day, Year)
2		1	176	>			9	1861		2/291	/2
4		30. Name And address of per	The who comp	leted cause	of death (Item	23a) (Type, P	rint) Rdf	216. Ro	ckii//	e, MD ?	20852.
Sta Registi		31. Date filed (Month, Day, Yea	7 6	32. Rec	sistrar's Signa	ture				•	

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ March $20\overset{\mathrm{Year}}{1}2$ Eston C. Wright A^{M} 0824 Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death **Examiner** 4b. City. Town, or Location of Death 840 Nottingham Road E1kton Ceci1 . Age (In yrs. last birthday, If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 😿 M 2 🗆 F Days June 13. Hours Min. Tennessee Director 411-48-5955 78 Ĩ′933 Usual Residence of Decedent item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2 🔯 No Maryland Ceci1 E1kton 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral United States 840 Nottingham Road 21921 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces? 1952 to 1 X Yes 2 \(\sum \) No 1954 Black, White, etc ģ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗓 No Specify: 1954 Specify: White Completed 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Automobile permit. Page 1 and 2 should be filed within 7 Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event the man Elementary/Seconday (0-12) College (1-4 or 5+) Manufacturing Final Repairman Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Wylie Escue Wright Julie E. Buck 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sarah F. Wright/Wife 840 Nottingham Road, Elkton, 20b. Place of Disposition (Name of Cemptery, grematory or other place)
Gilpin Manor
Memorial Park 20a. Method of Disposition March 15 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) Elkton, MD 2012 22. Name and Address of Facility Hicks Home for Funerals, P.A. 21. Signal re of Funeral Service Licensee 103 W. Stockton Street, Elkton, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ DEMENTIA disease or condition resulting in death) Medical Examiner Due to (or as a consequence of) Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) cate has been signed by the attending physician and page 2 should be detached for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physicis completed filled in by the funeral director, page 2 should be detached for use as the bur Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3

Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown 4 Pregnant a Month Day Year Pregnant at time of death 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? b 2 № No 3 ☐ Probably 4 ☐ Unknown 1 Yes Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performe death? 25. Was case referred to medica Certificate: To Be 26. Place of Death (Check only one) examiner? Other: 1 🔲 Yes 2 No 4 Nursing Home 5 Residence 6 Other (Specify 1 Inpatient 2 I ER/Outpatient 3 I DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred **Natural** 5 Pending 2 🗌 No Accident Investigation Suicide 6 Could not be 3 ☐ Suicide 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical

gul

State Registrar 29a. Certifier

29b. Signature and title of certifier

31. Date filed (Month. Dav. Year)

DHMH 17 Rev 7/2009

32. Registrar's Signature

1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SHAHNAWAZ KHAN
2533 AUGUSTINE HERMAN, HWY, SUITE A, CHESAPEAKE CITY, MD 21915

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

D0062190

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First Middle Last) 2. Date of Death 3. Time of Death Month Physician/ WATSON JOSEPH **JEFFREY** aM Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Plate Age (In vrs. last birthday) If Unde 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Director 2598 1 ★ M 2 □ F MAY 3,1961 MARYLAND 50 show 10b. County 10c. City, Town or Location 10d. Inside City Limits Director or 28a-f VA COLONIAL BEACH KING GEORGE 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? "natural", or items 23a o Funeral 22443 U. S. A. 341 RIVERWOOD DRIVE Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian. Armed Forces Completed by 1x Never Married 2 Married Yes 2 No If Yes, Give Year or Dates 1 Yes 2 No Specify: Specify: 3 Widowed 4 Divorced BLACK er than "natur, the Medical E Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) SEAFOOD WATERMAN is marked other Be Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည RICHARD JEROME WATSON JR. JANE FLORENCE BRISCOE 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code Department of Health a Important: If item 27 is any injury or other trai 10837 VISTA GARDENS DR., BOWIE, MD 20720 LILLIAN WATSON/SISTER Baltimoré, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State MARCH 1 Burial & Cremation 3 Removal from State 15, 2012 ALEXANDRIA, VA 4 ☐ Donation 5 ☐ Other (Specify) METRO . CREMATORY 22. Name and Address of FacilityRAYMOND FUNL • SERVICE, P.A. 5635 WASHINGTON AVE., LA PLATA, MD 20646 M00641 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, shock, or heart failure. List only one cause on each Immediate Cause (Final Ph_sician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner equantially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) or Attending Physician: The law requires that the death certificate be executed and burial-trar that initiated events Due to (or as a consequence of) resulting in death) Last physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d Date of delivery 3 Ectopic pregnancy in the past 12 months? Dav 5 Other (specify) Pregnant at time of death a Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available this certificate has autopsy prior to completion of cause of death? 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 **2** No Hospital Other: 1 🗌 Yes ျ 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred Director: After (Month, Day, Year) Natural Accide 5 Pending М 1 Yes 2 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined within 24 hours a To the Funeral I Hospital Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) Centennia Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 11 Day Physician/ Mont 2012 March 5:02 РМ John Addison Armstrong Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** Montgomery Shady Grove Adventist Hospital Rockville Social Security Number unk 8. Date of Birth (Month, Day, Ye 9. Birthplace (State or Foreign **Funeral** Min. Days 66 Months Hours Countryunk Director 19 1945)ec Usual Residence of Decedent ms 23a or 28a-f show must be notified at 10a. State 10b. County 10d. Inside City Limits 10c. City. Town or Location with the Maryland Director 1 Yes 2x No DC 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Important: If tem 27 is marked other than "natural", or items 23a any injury or other traumatic event, the Medical Examiner must be any injury or other traumatic event, the Medical Examiner must be once. Funeral 3695 Highwood Dr. SE 20020 USA death w Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 2X No Black, White, etc. þ 1 Never Married 2 Married 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: Black Specify: Completed 3 - Widowed 4 - Divorced 16a. Decedent's Usual Occupation Un (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry Un (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) unk unk Be 17. Father's Name (First, Middle, Last) unk Maryland 18. Mother's Name (First, Middle, Maiden Surname) and Mental F 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) James Sade - friend 3695 Highwood Dr SE; Washington, DC 20020 Saltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☒ Other (Specify) in State 21. Signature of the Service Lichnes Ronal 22. Name and Address of Facility State Anatomy Board 655 W. Baltimore St; Baltimore, MD 21201 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line. Approximate Interval Between a CARDIO PULMONARY Onset and Death Ph sician/ disease or condition Medical resulting in death) Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of): attending physician and for use as the burial-tran that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical that the death certificate be 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Box 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No Day Year Pregnant at time of death signed by the a 9 Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Diabetes 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Division of Vital Records, Completed potension 24a. Was an 24b. Were autopsy findings available prior to completion of cause of cate has k autopsy perform death? Yes 2 And or Attending Physician: The Be 25. Was case referred to medical ral director, 26. Place of Death (Check only one) examiner? Hospital: 2 PN0 1 Anpatient 2 ER/Outpatient 3 DOA |은 4 Nursing Home 5 Residence 6 Other (Specify) Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred After Natural injury 5 Pending s after dea...
ral Director: Aftr Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined To the Hospital o within 24 hours af To the Funeral Di completed filled in Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) e secold 71323 3/12/12 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 9901 medical Ctr Dr Rochville MD eniqalla MD 31. Date filed (Month, Day, Year) 1 2012 32. Registrar's lignatur State Registrar

3/11/120

John

AF TO FOR

mes Wesley /		1- For State Certificate of Death	ntal Hygier		1. No. 20	12 0875
Physici		Registrar 1. Decedent's Name (First, Middle,Last)		te of Death	*	3. Time of Death
ledical Exami		James Wesley Allen		nth I rch 8, 20		1536 hrs
		4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location	of Death		4c. County of I	Death
		Saint Mary's Hospital Leonardtown	(a) 041/a 0 D	ata of Dieth	St. Mary's	Dirthplane (State of
Funeral Director		Months Days Hours		ate of Birth 1/11/1		9. Birthplace (State or foreign NC
Director		224-80-6746 1 Mm 2 F 59 Yrs. Months Days Hours	04	*/ 11/	1932	Country) INC
any		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location				10d. Inside City Limits
		MD St. Mary's Lexington Park				1 Yes 2 No
Maryland 28a-f show	cto	10e. Street and Number 10f. Zip Code		100	g. Citizen of What	Country?
ith the Maryland 23a or 28a-f sho	Director	2426 Chancellors Run Road 20653			USA	
with ns 23.	<u>ra</u>	11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Ori				American Indian, Black,
death or iter	Funeral	1 Never Married 2 Married Armed Forces? If Yes, specify Cuban, Mexican Yes 2 No		etc.)	White, e	White
after	by F	3 Widowed 4 Divorced of Divorced of Divorced of Divorced of Dates:			Specify:	
hours	Per	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+)		one I1	16b. Kind of Busin	ess/Industry
336 thin 72 hou ne. • than "nat edical Exa	ple	12 Upholsterer			Uphols	tery
5-003 iled withi Hygiene. I other th	Completed		er's Name (First,	Middle, Ma	aiden Surname)	
215 be file ntal H rked c	Be (Octal Newsey III	hel Jone			
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mond be filed within 72 hours after death with the Maryland Important: If item 27 is marked other than "natural", or items 23a or 28a-f she injury or other traumatic event, the Medical Examiner must be notified at once	Ţ	19a. Informant's Name/Relationship (Type, Print) Brenda Copeland Sister 19b. Mailing Address (Street and Nur 1309 Sparrow Road	mber or Rural Ro d Chesar	oute Numb Deake	er, City or Town, VA 2332	State, Zip Code) 5
and 2 and 2 lealth item 2 trau		20a. Method of Disposition 20b. Place of Disposition (Name of cemetery,	Date		20c. Location - Ci	ty or Town, State
ages lant of l		1 Burial 2 X Cremation 3 Removal from State crematory or other place) Atlantic Crem	03/20/	/2012	Glen B	urnie MD
Baltimore, bernit Pages I an Department of Hea Important: If iter		4 Donation 5 Other Specify: 21. Signature of Funeral Service Licensee 22. Name and Address of Facilit 23. Name and Address of Facilit 24. Donation 5 Other Specify: 25. Name and Address of Facilit 26. Name and Address of Facilit 27. Name and Address of Facilit 28. Name and Address of Facilit 29. Name and Address of Facility ty Simpli	icity	Crem &	Fun Service	
E P P B		Thomas Allen P.	.A. 7090	O Rid	ge Rd Ha	
Physician		23a. Part I. Enter the disease, of complications that caused the death. Do not enter the mode of dying, such as of failure. List only one cause on each line.	cardiac or respir	atory arres	st, shock, or heart	Approximate Interval Between Onset and
Medical Examiner		Immediate Cause (Final disease a. Upper Gastrointestinal Hemorrhage				Death
		or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, b.				
	iner	if any, leading to immediate Due to (or as a consequence of):				
ted nsit	Examiner	(Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):				
ox 68760, eath certificate be executed attending physician and for use as the burial - transit	dical	UNPENDED AMENDED	····			
760 cate b physic	/Me	IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the			23d. Date of de	
certificate anding physics as the b	iai	250. Was decedent pregnant in the past 12 months?	ic pregnancy		Month	Day Year
Box te death of the atten ted for us	Physic	1 Yes 2 No 9 Unknown 9 Unknown				
- # ≥4	by Pt	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pa Cirrhosis of liver				te to the cause of death? Probably 4 Unknown
ords, P.C. w requires that is been signed?		CHITIOSIS OF INVE	24	4a. Was an	24b. We	re autopsy findings available
of Vital Records, ng Physician: The law requir the centificate has been s neral director, page 2 should t	Completed		—	autopsy perform		r to completion of cause of th?
	Ş	00 Pt		✓ Yes 2	No 1 _	Yes 2 No
ital lician: s certifi rector,	Be	25. Was case referred to medical examiner? 26. Place of Death 26. Pla	Nursing Home		esidence 6	Other:
n of Vi ding Physia After this funeral dir	. To	27. Manner of Death 28a. Date of Injury 28b. Time of Injury 28c. Injury at Work			w injury occurred	
Sion (ttending death. ctor: At	tion	1 Natural 5 Pending (Month, Day, Year) 1 Yes 2	No			
Division Lal or Attendi rs after death. The Director: //	Certification:	2 Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, et		ocation (Str r Town, Sta		or Rural Route Number, City
DIVI Hospital or 24 hours after Funcral Directly filled in 1	Ser	4 Homicide determined (Specify)		100011, 010		
Ho Tely		29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred.	lace, and due to	the cause((s) and manner as	stated. to the cause(s)
To the within To the comple	Medical	29b. Signature and title of certifier (29c. License number				(Month, Day, Year)
		250. Significate and time of certainer		- 1	March 9, 201	
150 1		30. Name and address of person who completed cause of death (Item 23a)			,	
ah.		Carol Allan, MD Assistant Medical Examiner 900 W. Baltimore Street, Baltimore	ore, MD 212	223		
Si	tate	31. Date filed (Month, Day, Year) AAD 0 1 2012				

DHMH 17 Rev 1/2001 OCME 2006

OCME

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Jean Marie Alley Pay 124 2012 2:58 PM March Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Stella Maris Hospice Center Baltimore Co. Timonium 5. Social Security Number If Under Year If Under 24 Hrs. 7. Age (In vrs. last birthday) 8. Date of Birth Birthplace (State or Foreign Country) Funeral Months Davs Hours (Month, Day, Year) 216-34-3452 **Director** 1 🗆 M 2 🕱 F 73 Yrs Sept.1,1938 Maryland Usual Residence of Deceder 28a-f show 10a. State "natural", or items 23a or 28a-f sho edical Examiner must be notified at 10c. City. Town or Location 10d. Inside City Limits Director MD 1 X Yes 2 No N/A Baltimore City 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21224 7208 Fait Avenue United States Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian Black, White, etc. þ 1 Never Married 2 Married ☐ Yes 2 🔀 No Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. Specify. Completed 3 Widowed 4 X Divorced White Year or Dates permit. Page 1 and 2 should be filed within 72 hours pepartment of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical! 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) United States Elementary/Secondary (0-12) College (1-4 or 5+) 10 Years Telephone Operator Government Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2012 ပ Douglas Boblitz Hattirae Fincham 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) MARCH 14, 7208 Fait Ave. Victoria J. Sweetsir (Daughter) Baltimore, Maryland 20a, Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place. 1 Burial 2 X Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Hilltop Service Corp; 3/19/2012 Towson, Maryland 21. Signat f Funeral Service Licevie 22. Name and Address of Facility Duda-Ruck Funeral Home of Dundalk, Inc. 7022 Wise Ave. Dundalk, Maryland 21222 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or their failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ END STAGE CHRONIC OBSTRUCTIVE PULMONARY DISEASE disease or condition resulting in death) Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Examin resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 attending properties for use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 - Ectopic pregnancy in the past 12 months? Year Day 5 Other (specify) Pregnant at time of death Yes 2 X No the 9 Unknown 9 Unknown ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown 1 Yes JEAN ALLEY funeral director, page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an certificate has autopsy performed? Yes 2**X** No Hospital or Attending Physician: The 2 No 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital Other: 1 🗌 Yes 2 X No ပ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 X Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred After 1 X Natural 5 Pending n 24 hours after death.

e Funeral Director: Ai 1 Yes 2 No Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier

Registrar DHMH 17 Rev 06-2011

State

To the !

29b. Signature and title of

30. Name and address of per

JONES.

3 🗶 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

29d. Date signed (Month, Day, Year)

TIMONIUM, MD 21093

2300 DULANEY VALLEY RD.

who completed cause of death (Item 23a) (Type, Print)

1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Time of Death Year Day Month **Physician** 3:00 PM 6 2012 3 David Bruce Ayres /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner ROSCOLOLO If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. Franklin Square i. Social Security Number 6. Sex HOSPITA Baltimore 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Funeral Months 1**X** M 2□ F 61 Director 219-60-9689 02 - 21 - 1951Marvland Usual Residence of Decedent 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits show Department of Health and Mental Hygiene. Important; if items 23a or 28a-f show important; if item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Profice Lexanting or the traumatic event, the Profice Lexanting or the profice of the prof Director 1 ☐ Yes 2 ☑ No MDBaltimore Baltimore 10f. Zip Code 10e. Street and Number 10g, Citizen of What Country? USA 21219 2503 Lodge Farm Road Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. Int: If item 27 Is marked other than "natural", or ite 1 Never Married 25 Married Baltimore, Maryland 21215-0036 1 ∐Yes 2XXXNo Specify Ş Q Specify: White 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Auto Mechanic Tears 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Grace Jean McCann Andrew Ayres ပ 19a Informant's Name/Relationship (Type Print)
Mrs. Bonnie Sue Ayers
Bonnie Sue Stewart (19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) (wife) 2503 Lodge Farm Road Baltimore MD 21219 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 ☐ Burial 2 🙀 Cremation 3 ☐ Removal from State 03/20/2012 Towson Hilltop Service Corp : 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee Duda-Ruck Funeral Home Of Dundalk Inc. 7922 Wise Avenue Dundalk MD 21222 Approximate Interval Between Onset and Death Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician Cardiomyopath a ISChemic /Medical Due to (or as a consequence of): Examiner Drongry Artery Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine P Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death.
Puneral Director: After this certificate has been signed by the attending physician and and burial-tran P.O. Box 68760% Due to (or as a consequence of): cate has been signed by the attending physician page 2 should be detached for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 🗆 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ≥ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □Yes 2 □No 24a. Was an autopsy performed? funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No 1 ☑Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 Natural 5 ☐ Pending investigation Injury 1 ☐Yes 2 ☐ No 2 Accident filled in by the 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #19a Per INF G925 3/30/2012 JH
State of Maryland / Department of Health and Mental Hygiene

State Registrar

completely

To the Within 24

(Check only

29b. Signature and title of certifier Chichi

31. Date filed (Month, Day, Year)
MAR 2 1 2012

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

9 y (es

NWachinemere, MD

MAC

memere

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

D63176

9000 Franklin Square Drive Baltimore, MD

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 12:33 PM March RUTH C. ALEGIOJO ZOIZ Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Maryland Tene Himore Social Security Number (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth **Funeral** 9. Birthplace (State or Foreign 1 □ M 2 💢 F Days Months Hours Min. 1-11-1955 Director PHILIPPINES 212-77-7897 Usual Residence of Decedent th and Mental Hygiene. 27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits Director NOTTINGHAM BALTO. MD 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3 CRABTREE COURT 21236 PHILIPPINES APT G Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian Armed Forces Black, White, etc. 1 Never Married 2 Married þ ☐ Yes 2 XNo Maryland 21215-0036 Specify: ASIAN 1 Yes 2 XNo Specify: If Yes, Give Completed 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) **HEALTH INDUSTRY** NURSE Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) MARIA CLACARAY WINSLAO ALEGIOJO 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, permit. Page 1 and 2 st Department of Health ar Important: If item 27 is any injury or other trau NOTTINGHAM, MD. 3 CRABTREE COURT APT.G 21236 **SPOUSE** ZALDY MALABUG Baltimore, 20a. Method of Disposition
1 Burial 2 Cremation 3 Removal from State 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 4 ☐ Donation 5 ☐ Other (Specify) SILAY PUBLIC CEMETERY UNK. PHTI IPPINES 2 Signatur of Imore 22. Name and Address of Facility SCHIMUNEK FUNERALHOME, INC. 9705 BELAIR ROAD NOTTINGHAM, MD. Part 1. Enter the disease or complications shock, or heart failure. List only one cause pat caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Stage disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine Due o r as a conse uence of oronar Due to (or as a consequence of): resulting in death) Last bunalattending physician for use as the buna Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 4 Pregnant Pregnant at time of death 5 Other (specify) Month Day Year Yes 2 No Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by page 2 should be 1 Yes 2 No 3 Probably 4 Onknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy death? performed 2 🗆 No Yes 2 1 Yes Division of Vital Be 25. Was case referred to medica 26. Place of Death (Check only one) examiner? 1 ☐ Yes 2 ☐ No Other: မြ 1 Inpatient 2 I ER/Outpatient 3 I DOA this 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death Certificate: 28a. Date of injury 28c. Injury at 28b. Time of 28d. Describe how injury occurred (Month, Day, Year) 1 Natural 5 Pending work Accident
Suicide 1 🗌 Yes 2 🗌 No Investigation 24 hours after deat Funeral Director: filled in by the 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Example: On the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 🗆 within 2 To the only one Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature, and title of certifier 29d. Date signed (Month. Day, Year) Penx Ofen 03 17 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 10 ano State

DHMH 17 Rev 7/2009

Registrar

GIO

V

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #18 Per FH G925 3/21/2012 JH
State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 2012 Year Physician/ MARCH 15, RICHARD AARONS 2:10 AM Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death TUDOR HEIGHTS ASSISTED LIVING BALTIMORE BALTIMORE Social Security Number If Under 1 Year If Under 24 Hrs. 6. Sex 1 X M 2 □ F **Funeral** 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Days Min. Hours Country) 219-28-5628 0970271930 **Director** Yrs 81 PA Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location the Maryland Director 10d. Inside City Limits notified 28a-f MD BALTIMORE 1 Yes 2 X No BALTIMORE ò 10e. Street and Number 10f. Zip Code ms 23a or must be i 10g. Citizen of What Country? Funeral 3407 OLD FOREST ROAD 21208 USA items (within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ⚠ Yes 2 ☐ No 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Examiner ò ģ 1 ☐ Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: "natural", Completed 3 Widowed 4 Divorced Specify: WHITE Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) than Elementary/Seconday (0-12) College (1-4 or 5+) CONSULTANT CHAMBER OF COMMERCE other of Health and Mental Hygi item 27 is marked other other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ HAROLD **AARONS** SADIE Sadye WEINBERG 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is any injury or other trauonce. LONNA SHAIVITZ/WIFE 3407 OLD FOREST ROAD, BALTIMORE, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) OHEB SHALOM CEMETERY 03/15/2012 REISTERSTOWN, MD Signature of Funeral Service Licensee 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final 121 Onset and Death ₽nysician/ tin disease or condition resulting in death) Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, Examine if any, leading to immediate Due to (or as a consequence of): tran gue that initiated events resulting in death) Last Due to (or as a consequence of): physician a the burial-Physician/Medical requires that the death certificate be Division of Vital Records, P.O. Box 68760 as attending IF FEMALE: for use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Pregnant at time of death 5 Other (specify) Month Day 2 No the Linknown 9 Unknown by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by has been signe te 2 should be c Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy page performed? certificate | Yes 2 No Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 ☐ Yes _2 ☐ No Hospital iASSISH D Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Mann Death 28a. Date of injury Certificate: 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred (Month, Day, Year) Natural 5 Pending Acciden Accident 1 ☐ Yes 2 ☐ No Investigation the Funeral Director; 3 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated, 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 To the I 29b. Signature and title of cert 29c. License number 29d. Date signed (Month, Day, Year) 3/15/12 115 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) N 571 MALT 1 2012 31. Date filed (Month State 32. Registrar's Signature MAR 2

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 30am Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner County of Deat Center 20 Creck Me Social Security Number If Under 1 If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) 8. Date of Birth **Funeral** M 2 🗆 F Hours (Month, Day, Year) 02/02/1932 Min. Country) 060-26-4396 NY Director Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10b Count should be filed within 72 hours after death with the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2X No ANNE ARUNDEL SHADYSIDE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20764 USA 1217 PINE AVENUE Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 XYes 2 No Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 WHITE If Yes, Give Year or Dates 1 Yes 2 XNo Specify: permit. Page 1 and 2 should be filed within 72 hours aft Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", any injury or other traumatic event, the Medical Exan Specify Completed 3X Widowed 4 □ Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) U.S. GOVERNMENT BROADCASTING ENGINEER Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ GOODMAN UNKNOWN ALPINE SYLVIA 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) JENNIFER MARTINO / DAUGHTER 3854 WILDWING DRIVE N.TONAWANDA, NY 14120 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State ARLINGTON CEMETERY
AMUNO CEMETERY 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State 03/19/2012 BALTIMORE, MD 4 Donation 5 Other (Specify) Si alvire Service Kiden 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD PIKESVILLE, MD 21208 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one gause on each line. Approximate Interval Between Onset and Death shock, or heart failure. List only one Immediate Cause (Final Stroke Ph. sician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury To the Hospital or Attending Physician: The law requires that the death certificate be executed anding physician and use as the burial-trar that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy atten for u in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death 5 Other (specify) the g
Unknown signed by to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed been si should I 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 s autopsy performed Yes 2 1 this certificate **Division of Vital** 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital Other: 1 🗌 Yes 2 **N** No ည 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28c. Injury at work? 1 ☐ Yes Certificate: 28b. Time of 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director: After completed filled in by the funer 1 Natural 5 Pending 2 🗌 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Meglical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated nly on Tertifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29h Signature a nd title of certifier 29d. Date signed (Month, Day, Year) R1351020 cause of death (Item 23a) (Type, Print) Jeb. Glen Bunie imp 21061

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Beason March Patricia 20 /2 9:50 A M Medical Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 8. Date of Birth (Mpnth, Day, Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) If Unde **Funeral** Director 1 □ M 2 🗹 F or 28a-f show 10b County 10c. City, Town or Location traumatic event, the Medical Examiner must be notified at **Funeral Director** nside City Limits 1 Yes 2 □ No 10f. Zip Code 10g. Citizen of What Country? items 23a Page 1 and 2 should be filed within 72 hours after death 12. Was Decedent Eyer in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Race - American Indian Black, White, etc. is marked other than "natural", or Completed by 1 Never Married 2 Married 1 ☐ Yes If Yes, Give Baltimore, Maryland 21215-0036 1 Yes 2 No Specify. 3 ☐ Widowed 4 ☑ Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16h. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) and Mental Hygiene. aundemat Be Father's Name (First, Middle, Last) Name (First, Middle, Maiden Sername) ပ္ 19a. Informant's Name/Relationship (Type, Print) Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 211 athanie injury or other 20b. Place of Disposition (Name of 20a. Method of Disposition Department of H
Important: If ite
any injury or otl
once. 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses Home, P. Baito MA North 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ (ardiovascular Discase Atherosclerotic disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Due to (or as a consequence of) resulting in death) Last Due to (or as a consequence of): Completed by Physician/Medical Box 68760 IF FEMALE: detached for use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No 3 Ectopic pregnancy
 5 Other (specify) Day Pregnant at time of death Month Year 1 ☐ Yes ∠ ⊭ 9 ☐ Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? should be Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No certificate has page 2 autopsy performed? Yes 2 No Division of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 4 Nursing Home 5 Residence 6 Fother (Specify) ျှ 1 \(\text{Yes} 2 No Other: 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Director: After 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident Investigation filled in by the 3 Suicide
4 Homicide 6
Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) To the Hospital within 24 hours To the Funeral I Hospital Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) ns Rajaja m MO D0057465 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Baltomore ND 21209 NSRAJAPAKSEMO Smin. 203

DHMH 17 Rev 06-2011

State Registrar

			For State	State of Marylan		artment of F <i>tificate of L</i>		Mental Hyg	jiene		00761
			Registrar 1. Decedent's Name (First, Middle, La	st)	Cer	uncate or L	Deall I	2. Date of Dear	Reg. No. 2	112	3. Time of Death
ı	Physicia Medic		MARY FI	ORENCE BECKL	ES			MARCH	12 ^{Day} 2012	Year	9:10PM
Sugar	Examin		4a. Facility Name (if not institution, give	· ·			Location of Death		4c. County		OFFI G
-	Funeral		LARKIN CHASE NUR 5. Social Security Number 6.8		ast birthday)	BOWIE If Under 1 Year	If Under 24 Hrs.	8. Date of Birth			AGE S ace (State or Foreign
	Director			I□M2 X F 94	Yrs.	Months Days	Hours Min.	DEC. I	9 ^{Year)} 917	GUYAI	ďΑ
	and show at	ě	Usual Residence of Decedent 10a, State 10b. County	10c. Cit	y, Town or Lo	cation	l			10	d. Inside City Limits
	Maryla 28a-f	irect	MD PRINCE	GEORGE'S BO	WIE						1 X Yes 2 No
	ith the 3a or t be n	ralD	10e. Street and Number 14902 DOWNEY COU	ID.III.		10f. Zip Code 207	7.0.1		10g. Citizen of V		
	ems 2	Funeral Director	11. Marital Status	12. Was Decedent Ever in U.S	S. 13. V	Was Decedent of Hi	spanic Origin? (Sp	ecify Yes or No-		e - America	
21215-0036	1 and 2 should be filed within 72 hours after death with the Maryland f Health and Mental Hygiene. item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	þ	1 ☑ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	Armed Forces? 1 ☐ Yes 2 █XNo If Yes, Give Year or Dates.		f Yes, specify Cuba □ Yes 2 🛣No		Rican, etc.)	Blac Specify:	k, White, e	BLACK
15-(72 hou n "nat ſedica	Completed	15. Decedent's I (Specify only highest g	rade completed)	(Give I	dent's Usual Occupa kind of work done of ONOT use retired)	ation during most of work	ing	16b. Kind of Bu	usiness/Ind	ustry
212	within giene. er thau		Elementary/Secondary (0-12)	College (1-4 or 5+)	TEAC	,			PR	LVATE	
Maryland	2 should be filed within 72 h and Mental Hygiene. 7 is marked other than " traumatic event, the Mec	To Be	17. Father's Name (First, Middle, Last) DAVID BECKLES				18. Mother's Nam DORCA	e (First, Middle, N S NERO	Maiden Surname	e)	
lary	should and M is mar aumati		19a. Informant's Name/Relationship (Type, Print)	19b. Mailir	ng Address (Street a	and Number or Run	al Route Number,	City or Town, S	tate, Zip C	ode)
	and 2 s Health tem 27		BEVERLY VANCOO' 20a. Method of Disposition	TEN/DAUGHTER		2 DOWNEY		BOWIE, M			716
nor	0		1 Burial 2 Cremation 3 Care Donation 5 Other (Spec	Removal from State	emetery, cren	sition (Name of natory or other plac	e)	Date	20c. Location -	•	
Baltimore,	permit. Page Department Important: I any injury or		21. Signature of Funeral Service Licer	1 01	22		ss of Facility $ J . $	B. JENK	KINS FUN	IERAL	HOME, INC.
_		Н	23a. Part 1. Enter the disease, or com	anlications that caused the deat		474 LANDO				RYLAI	Approximate
see.	Physician/		shock, of fleart failule. List only Immediate Clause (Final	one cause on each line. CARDIAC ARR			9,		,		Interval Between Onset and Death
	Medical Examiner		disease or condition resulting in death)	Due to (or as a consequ		n					
	Laminici	ē	Sequentially liet conditions, if any, leading to immediate	b. FAILURE TO Due to (or as a consequ		Е					
×	uted d ansit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	C							
90	e be executed ysician and e burial-transit	al Ex	resulting in death) Last	Due to (or as a consequ	uence of):						
3760	ficate by physical properties in the last the la	fedical		d							
89 ×	th certification in the second	ian/N	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregna	aldeath 3		:y			te of delive	*
. Box	hat the death certificed by the attending detached for use as	Physician/M	in the past 12 months? 1 ☐ Yes 2 ☒ No 9 ☐ Unknown	4 Pregnant at time of a	death 5 L	Other (specify)			Мо	ntri	Day Year
P.O.	s that the	by PI	Part II. Other significant conditions	contributing to death but not res	sulting in the u	nderlying cause giv	en in Part I.				e cause of death?
rds,	requires been sig should b	eted			, , , , , , , , , , , , , , , , , , , 						ably 4 🛭 Unknown
of Vital Records,	The law rate has b	Completed						24a. Was a autops perfor	med?	Vere autop prior to con death?	sy findings available npletion of cause of
ital	Physician: The this certificate eral director, pa	Be	25. Was case referred to medical examiner?	Hospital:		Othe	ace of Death (Chec	k only one)			
of V	ding Phys h. After this funeral di	e: To	1 ☐ Yes 2 😾 No 27. Manner of Death	1 Inpatient 2 28a. Date of injury	28b. Time of	it 3 🗆 DOA	4 LA Nursing Ho	ome 5 Reside			
ion	ending eath. or: Afte the fun	Certificate:	1 X Natural 5 Pending 2 Accident Investigatio 3 Suicide 6 Could not		injury		? Yes 2□No				
Division	al or Attendi s after death. I Director: A ed in by the fi		4 Homicide determined			eet, factory, office		28f. Location (St City or Town		er or Rural I	Route Number,
-	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transi	Medical	(Check 2 Medical Exam	vsician: To the best of my knowniner: On the basis of examinations Practitioner: To the best of r	n and/or invest	tigation, in my opinio	n, death occurred a	t the time, date an	nd place, and due	to the cau	se(s) and manner stated.
	To the within To the comple	2	29b. Signature and title of ceruffier	33 7 Tacadoners to the best of f	y m.owieuge,	29c. License			29d. Date signed		
						D57	028		MARCH 1	4, 20	12
	5		30. Name and address of person who ADITYA CHOPRA M				231 ANNAT	POLIS.MA	RYLAND	21401	
	Stat Registra		31. Date filed (Month, Day Year)	32. Registrar's Signa	ture						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ MARCH 11 2012 6:25 AM BUTLER **MADURO** WILLIAM Medical 4a. Facility Name (if not institution, give street and number) 4b. Cify, Town, or Location of Death 4c. County of Death Examiner TAKOMA PARK MONTGOMERY WASHINGTON ADVENTIST HOSPITAL If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Social Security Number 9. Birthplace (State or Foreign **Funeral** Days Hours **Director** 577-98-3892 1 X M 2 D F 34 SEPT. 16 1977 WASHINGTON, DC Usual Residence of Decedent 28a-f show 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State injury or other traumatic event, the Medical Examiner must be notified at Director DC 1 X Yes 2 No WASHINGTON 5 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 1616 H STREET S 20003 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black White etc. 1 Never Married 2 ☐ Married than "natural", or þ ☐ Yes 2 X No Yes, Give Baltimore, Maryland 21215-0036 hours after 1 Yes 2 No Specify Specify. BLACK Completed 3 Widowed 4 Divorced Year or Dates Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) LIFE GUARD PRIVATE 12TH other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) is marked ည MADURO WILLIAM BUTLER SR. RENEE D. RANSOM 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 1616 H STREET S.E. WASHINGTON, DC 20003 1 and 2 s of Health item 27 BARBARA DOY/AUNT Important: If iten 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 🖾 Burial 2 🗆 Cremation 3 🗆 Removal from State 3/20/2012 LANDOVER, MARYLAND HARMONY CEMETERY 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility J. B. JENKINS FUNERAL HOME, INC. 21. Signature of Funeral Service Licenses 23a. Part 1. Ent the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 7474 LANDOVER ROAD HYATTSVILLE, MARYLAND Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Examin Cause (Disease or injury that initiated events resulting in death) Last the burial-trar Due to (or as a consequence of): iding physician Physician/Medical Division of Vital Records, P.O. Box 68760 as IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy the past 12 months? Month Day Year 2 No Unknown Unknown by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4. ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an To the Hospital or Attending Physician: The law within 24 hours after death.

To the Funeral Director: After this certificate has autopsy performed? 2. No 1 🗌 Yes Yes 2 No completely filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be Hospital Other: 1 ☐ Yes 2 ☐ No 1 Inpatient 2 ER/Outpatient 3 DOA မ 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1. Natural 5 Pending 1 ☐ Yes 2 ☐ No Acciden Accident Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined 29a. Certifier 1. 🖅 🗽 ifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practitioners to the best of my knowle 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 68040 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) lakama 7600 ignature Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year Month Physician/ TROY BOLDEN 08:33 A M MAR 2012 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** BALTIMORE HOSPITAL HARBOR 5. Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Dec 19, 7. Age (In vrs. last birthday) 9 Birthplace (State or Foreign **Funeral** 1 ₹ M 2 □ F Days Hours Months 145-54-7825 50 New Jersey Director Usual Residence of Decedent 28a-f shov 10b. County ms 23a or 28a-f shor must be notified at 10a State 10c. City, Town or Location 10d Inside City Limits with the Maryland Director 1 X Yes 2 □ No Baltimore MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 21223 2325 Hollins St #301 death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 14. Race - American Indian Medical Examiner Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates. Black. White, etc. ö þ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 filed within 72 hours after Specify: black 1 ☐ Yes 2 X No Specify: "natural" Completed 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working Il Hygiene. life. DO NOT use retired) Elementary/Seconday (0-12) 1 2 College (1-4 or 5+) food industry the cook t of Health and Mental Hygi If item 27 is marked other or other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Ruth Catherine McCoy မ Lewis Edward Bolden Page 1 and 2 should be 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2325 Hollins St #306; Baltimore, MD 21223 Alice Miller Bolden - wife 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Department or Important: If any injury or 9 4 Donation 5 Other (Specify) Rona Rona 22. Name and Address of Facility State Anatomy Board rector 655 W. Baltimore St; Baltimore, MD 21201 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ EMBO LISM 2 DAYS PULMONARY disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** THROMBOSIS 1 DAY VENOUS DEEP Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events and tran resulting in death) Last Due to (or as a consequence of): aftending physician a for use as the burial-Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?

1 Yes 2 No Month Year Pregnant at time of death Day cate has been signed by page 2 should be detack Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by ESRD on HD, DM type 2, Atrial Fibrillation, 1 ☐ Yes 2 ☐ No 3 → Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No Peripheral Vascular Disease 24a Was an performed 25. Was case referred to medical director, To Be 26. Place of Death (Check only one) Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 2X No 1 Yes 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 12 Natural 5 Pending work? 1 Pes 2 No

the Hospital or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760 funeral within 24 hours after death.

To the Funeral Director: All completed filled in by the fu

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) mD Stuy RES 001 MAR 2012 15

1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

28f. Location (Street and Number or Rural Route Number, City or Town, State)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

VISHAL VASAVADA SOUTH HANOVER ST BALTIMORE, MD 3001

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

31. Date filed (Month, Day, Year)
MAR 2 1 2012

Investigation

determined

6 Could not be

Accident

Suicide

4 Homicide

29a. Certifier

(Check

Medical

32. Registrar's Sign

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND TTEM#10e.perFH, G925, 3/21/2012, WS.
State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 6:57 M Month 3 ortaMi Physician/ Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Wycombe Way Parkville Baltimore If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Social Security Number 7. Age (In yrs. last birthday) **Funeral** (Month, Day, Year) 10/21/1949 Days Hours Min. 220-52-6078 1 □ M 2 🖔 F **Director** 62 MD Usual Residence of Decedent 28a-f shov 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits must be notified at **Funeral Director** Parkville MD Baltimore 1 Yes 2 No 0e. Street and Number ò 10f. Zip Code 10g. Citizen of What Country? 23a 21234 USA or items 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Examiner Black, White, etc. Let 15-0036

Let 1215-0036

Let 1215 Completed by 1 X Never Married 2 Married 1 Yes If Yes, Give 1 Yes 2 No Specify. Specify: Black 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Homemaker Homemaker 12yrs Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Junus Buffalo Lois Oliver 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Leslie Sturtevant Daughter 2009 Richglen Dr Apt 2C Woodlawn MD 21207 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State ☐ Burial 2 X Cremation 3 ☐ Removal from State 03/19/12 Atlantic Crem Glen Burnie MD 4 ☐ Donation 5 ☐ Other (Specify) of Funeral Service Licenses 22. Name and Address of Facility Simplicity Crem & Fun Serv ThomasAllenPA 7090 Ridge Rd Hanover MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, shock, or heart failure. List only one caus Interval Between Onset and Death Immediate Cause (Final disease or condition athelosucionic Physician/ Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Physician/Medical Examiner Cause (Disease or injury that initiated events resulting in death) Last and attending physician To the Hospital or Attending Physician: The law requires that the death certificate be. Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?

1 Yes 2 No Month Day Year the g 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by holastro should be 1 ☐ Yes 2 ☐ No 3 🔁 Probably 4 ☐ Unknown 24b. Were autopsy findings available 24a. Was an prior to completion of cause of death? performed? this certificate 2 🗆 No 1 Tyes funeral director, 25. Was case referred to medical To Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28d. Describe how injury occurred 1 Natural 5 Pending s after death Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide determined within 24 hours a Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Description of the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier completely 2 Medical Examiner. On the basis of examination a lost involved at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier BIV2, completed cause of death (Item 23a) (Type, Print) OU 150 State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Physician/ ďΪΌ March 2012 17:05 Marina Lee Bragg Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Montgomery 4601 N. Park Avenue #810 Chevy Chase Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 7. Age (In yrs. last birthday) g. Birthplace (State or Foreign **Funeral** 06/01/1946 578-64-9895 65 1 □ M 2 🔀 Director NY Usual Residence of Decedent 28a-f shov 10a. State 10b. County 10d. Inside City Limits notified at 10c. City, Town or Location Director MD Chevy Chase Montgomery 1 Yes 2 XNo 10f. Zip Code ō 10g. Citizen of What Country? ms 23a or 4601 North Park Ave Funeral 20815 USA er than "natural", or items the Medical Examiner mu 13. Was Decedent of Hispanic Origin? (Specify Yes or No-12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian es, specify Cuban, Mexican, Puerto Rican, etc.) Black, White etc. by 1 Never Married 2 Married 2 X No Yes Maryland 21215-0036 White If Yes, Give Year or Dates 1 ☐ Yes 2X No Specify. Specify 3 Widowed 4 XDivorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry oe filed with... ∗al Hygiene. 'ser than "r (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Executive Secretary Insurance should be filed with h and Mental Hygien 7 is marked other th Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden_Surnam Joseph Podoski Barbara Lee Podoski ige 1 and 2 should be 1 not Health and Ments t: If item 27 is marked 1 or other traumatic e 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 201 Salem Ave Front Royal VA 22630 Richard L. Bragg Exspouse Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date permit. Page 1 Department of Important: If ii any injury or o 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State cemetery, crematory or other place) 03/15/12 4 ☐ Donation 5 ☐ Other (Specify) Atlantic Crem Glen Burnie MD 22. Name and Address of Facility Simplicity Crem & Fun Serv ThomasAllen PA 7090 Ridge Rd Hanover MD Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph_sician/ disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Exami burial-tra Due to (or as a consequence of) physician Physician/Medical certificate be Division of Vital Records, P.O. Box 68760 the attending p IF FEMALE 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 month 1 Yes 2 No 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ ☐ Live Βιπη ∠ ☐ , o... ☐ Pregnant at time of death Month Day Year 9 Unknown ed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? b 1 Yes 2 No 3 Probably 4 Unknown Completed plnous peen 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an has page 2 autopsy performed? Yes 2 No certificate 1 ☐ Yes 2 ☐ No To the Hospital or Attending Physician: funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner. 1 Yes Other: 4 Nursing Home 5 N Residence 6 Other (Specify) ြင် 2 🗌 No 1 Inpatient 2 ER/Outpatient 3 DOA after death.

Director: After this 27, Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 🖄 Natural 5 \square Pending 1 Yes 2 No filled in by the Accident Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined within 24 hours a

To the Funeral C Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check enly one)

Registrar DHMH 17 Rev 06-2011

W

State

Signature and title of certific

Date filed (Month, Day, Year,

moomit

CHEC MO, OME

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29c. License number

29d. Date signed (Month, Day, Year)

			For State Registrar	State of Maryla	nd / Depa		Health and	Mental Hy	giene Reg. No. 2	12 08766	
4000	Physicia Medic	al	Decedent's Name (First, Middle, Last) James	L.			Bohn	2. Date of Dea Month 63	Day	3. Time of Death	
	Examin Funeral Director	er	4a. Facility Name (if not institution, give st. Samasi- 5. Social Security Number 217-48-1056 1	ten Hoopi	tal last birthday)			AD 8. Date of Bird	4c. County o N/A h y, Year) 1950	9. Birthplace (State or Foreign Country)	
	e Maryland or 28a-f show notified at	Director	Usual Residence of Decedent 10a. State 10b. County MD N/A 10e. Street and Number	10c. C	City, Town or Lo			04720		10d. Inside City Limits 1 ☑ Yes 2 ☐ No	
36	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	by Funeral	3220 Tyndale Avenum 11. Marital Status 1 Never Married 2 Married	UC 2. Was Decedent Ever in UArmed Forces? 1 Yes 2 X No If Yes, Give		21214	Hispanic Origin? (Span, Mexican, Puer	Specify Yes or No- to Rican, etc.)	Black,	- American Indian, White, etc.	
Maryland 21215-0036	vithin 72 hours a iene. r than "natural" the Medical Ex	Completed	3 ☐ Widowed 4 ☒ Divorced 15. Decedent's Edur (Specify only highest grade Elementary/Secondary (0-12)	Year or Dates,	16a. Dece	dent's Usual Occu kind of work done O NOT use retired	pation during most of wo	rking	Specify: 16b. Kind of Bus Home Implementation	White iness/Industry provement	
aryland 2	ould be filed wad Mental Hyg marked othe matic event,	To Be	17. Father's Name (First, Middle, Last) Murray J. Bohn, S 19a. Informant's Name/Relationship (Type				18. Mother's Na Charlo t and Number or Ri	tte Cha	Maiden Surname) rlton		
Baltimore, Ma	age 1 and 2 sh ent of Health ar ht: If item 27 is y or other trau		Susan Wolff, Siste 20a. Method of Disposition 1 🔀 Burial 2 🗆 Cremation 3 🗆 R 4 🗀 Donation 5 🗀 Other (Specify)	20b. emoval from State	3220 Place of Dispo		Avenue,		e , MD 212	214 Sity or Town, State	
Baltir	permit. P Departme Importar any injur		21. Signature of Funeral Service Licensee	yBlair	22	Name and Addi 305 Har	ess of Facility Le ford Road	onard J. , Baltim	Ruck, In	nc. 21214	
	Medical Examiner		23a. Part 1. Enter the disease, or complic shock, or heart failure. List only one Immediate Cause (Final disease or condition resulting in death)	cause on each line.	mest	er the mode of dy	ing, such as cardia	c or respiratory arr	est,	Approximate Interval Between Onset and Death	
88 78	te be executed hysician and he burial-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease of Injury that initiated events resulting in death) Last	Due to (or as a conse							
P.O. Box 687	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit		IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown		Ectopic pregna Other (specify)	ncy		23d. Date of delivery Month Day Year			
rds, P.O.	requires that the peen signed by thould be deta	þ	Part II. Other significant conditions cont	ributing to death but not re	esulting in the u	nderlying cause o	given in Part I.	1 🗆 '	Yes 2 □ No 3	ute to the cause of death?	
al Reco	an: The law rificate has beto, page 2 s	Be Completed	25. Was case referred to medical			26.	Place of Death (Che	1 Tes	psy pri pped? de	ere autopsy findings available or to completion of cause of ath? Yes 1 No	
Division of Vital Records,	ding Physici th. After this cer funeral direc	은	27. Manner of Death Natural 5 Pending	spital: 1 Inpatient 2 [28a. Date of injury (Month, Day, Year)	ER/Outpatier 28b. Time of injury	nt 3 □ DOA 28c. Inju	iry at	7	lence 6 Other		
Divisio	ne Hospital or Attending Ph n 24 hours after death. e Funeral Director: After th oletely filled in by the funeral	al Certificate:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At I building, etc. (Spec.	ify)	eet, factory, office		City or Tow	n (Street and Number or Rural Route Number, Town, State)		
	To the Hosp within 24 ho To the Fune completely f	Medical	(Check 2 Medical Examine	ian: To the best of my kno r: On the basis of examinati Practitioner: To the best o	on and/or invest	tigation, in my opir	nion, death occurred t the time, date and	at the time, date a place, and due to t	nd place, and due to	o the cause(s) and manner stated. nner as stated.	
	3		30. Name and address of person who con	mpleted cause of death (Ite	m 23a) (Type, F	Print)	63000		3/16/0	70/2	
	Stat Registra	_	Pro Leep D -1 31. Date filed (Month, Day, Year) NAR 2 1 20	2 Scoll 32. Rigistrar's Sign	tature F	ale	1379: R.	-1 y more	mp2	1235	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ bet 145 A IZa Vant 20/2 March Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death HOSPICE Howar JOHNDIA 7. Age (In yrs. last birthday) 8. Date of Birth (Minth, Day, **Funeral** 9. Birthplace (State or Foreign Year) Min **Director** 1 □ M 2 🗹 F 84 North Carolina show notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director Columbia Howar D 28a-f MD 1 Yes 2 No 10e, Street and Number ö 10f. Zip Code 10g. Citizen of What Country? must be Funeral Stallion Lane items 23a ROON 21045 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces?
1 Yes 2 No If Yes, Give Year or Dates. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. the Medical Examiner Black, White, etc. ö þ 1 Never Married 2 Married Maryland 21215-0036 1 Yes 2 No Specify 3 ☑ Widowed 4 ☐ Divorced Black 'natural", Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. I other than " Elementary/Secondary (0-12) College (1-4 or 5+) SIMBI Be 17. Father's Name (First, Middle, Last) 18, Mother's Name (First, Middle, Malden Surname) and Mental ဂ KINNER 19a. Informant's Name/Relationship (Typ 19b. Mailing Address (Street and Number or Rural Route, Number, City or Town, ROON STALLION LANG Important: If item 27 any injury or other tra Baltimore, 20b. Place of Disposition (Name of cemetary, crematory or other place).

Columbia Mom. Cemakry 3 20a. Method of Disposition 1 🗹 Burial 2 🗌 Cremation 3 🗆 Removal from State 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility HONE FUNERAL HOME Howell Willie E. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ COMPLICATIONS OF DEMENTIN disease or condition MONTHS Medical resulting in death) Due to (or as a consequence of Examiner Sequentially list conditions, Dile to for as a consequence of if any leading to immedicause. Enter Underlying Examir Cause (Disease or injury that initiated events Due to (or as a consequence of): resulting in death) Last physician Physician/Medical certificate be P.O. Box 68760 the attending | IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months?

1 Yes 2 No Day Year Pregnant at time of death the 9 Unknown 9 Unknown signed by t d be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ To the Hospital or Attending Physician: The law requires Division of Vital Records, Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy 1 Yes 2 No 1 Yes funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) 1 Yes 2 X No မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify, this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: within 24 hours after death.

To the Funeral Director: After to completely filled in by the funer. 28d. Describe how injury occurred 1 X Natural 5 Pending Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

State Registrar DANIEUE DOBERMAN, MD 6336
31. Date filed (Month, Day, Year)
32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

164395

MARCH 17, 2012

CEDAR LANE COLUMBIA, MD 21044

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death MARCH Physician/ 908 A M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** County of Death 4A COUNT 8. Date of Birth (Month, Day, **Funeral** 9. Birthplace (State or Foreign **Director** 1 🗆 M 2 🗹 F 181 1936 North Carolina 10a. State 10c. City, Town or Location Page 1 and 2 should be filed within 72 hours after death with the Maryland Completed by Funeral Director or 28a-f sl MD 1 Yes 2 No DEVERN ь 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a o any injury or other traumatic event, the Medical Examiner must be U.S.A 12. Was Decedent Ever in U.S Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Race - American Indian, Black, White, etc. Armed Forces?

1 Yes 2 No 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify Specify: Black If Yes, Give Year or Dates 3 ₩idowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Secondary (0-12) RIK Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ျှ MMa COTT 19a. Informant's Name/Relationship (Type, Print) Batson 7816 Citadel NRICE 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility | OWELL Funeral Howell Millio & 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ ARDIAC HERHVTHMIA disease or condition resulting in death) Medical Examiner Sequentially list conditions, Examiner any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to for as a consequence on To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy
4 ☐ Pregnant at time of death 5 ☐ Other (specify) ____ 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? Month Year Dav 1 Yes 2 9 Unknown 2 🗌 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No within 24 hours after death.

To the Funeral Director: After this certificate 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner' 2 No Hospital Other: မ 1 Tes 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Certificate: 1 Natural 5 Pending 2 Accident
3 Suicide
4 Homicide 1 Yes 2 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 [Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one 29b. Signature and title of certifier D56853 MD Name and address of person who completed cause of death (Item 23a) (Type, Print) 21061-GLENBURNIE MD. 301 HUSPITAZ Ken 31. Date filed (Month, Day, Year) State Registrar

DHMH 17 Rev 06-2011

		For State		State	of Maryla	-	artmen <i>tificate</i>			and N	lental Hy	giene	201	2 02769
		Registrar 1. Decedent's Name	(First, Middle,	Last)		Cer	incate	OID	eaur		2. Date of De	Reg. No.	201	3. Time of Death
Physicia Medi					yrtle Br	own					Month March 1	9, 2012	Year	23:25 P ^M
Exami	ner	4a. Facility Name (if not institution, give street and number) Southern Maryland Hospital			4b. City,		Location on the contract of th	of Death			ounty of Dea			
Funeral	г	5. Social Security Nur	-	6. Sex	7. Age (In yrs.	last birthday)	If Under	1 Year	If Under		8. Date of Bir	th	9. Bi	rthplace (State or Foreign
Director		218 24 008 Usual Residence of		1 □ M 2 💢F	83	Yrs.	Months	Days	Hours	Min.	(Month, Da	ay, <i>Year)</i> 2 , 1928		ountry) cyland
land show dat	for		10b. County			ity, Town or Loc					-	<u> </u>		10d. Inside City Limits
e Mary r 28a-f notifie	Director	Maryland		George's		Brandywii								1 ☐ Yes 2XX No
with the 23a or	eral	10e. Street and Numb		aw Drive			10f. Zip	2061	13			_	en of What Co ited St	-
ING 21215-0036 Filed within 72 hours after death with the Maryland hal Hyglene. ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	Funeral	11. Marital Status	<u> </u>		cedent Ever in U		Vas Deced	ent of His	spanic Orig	gin? (Spe	cify Yes or No- Rican, etc.)		I. Race - Ame	erican Indian,
after after al", or xamir	Completed by	1 ☐ Never Marrie 3 ₩ Widowed 4		ed 1 🗆 Yes	ive X No		Yes 2			i, i derto	riteari, etc.)	Sp	Black, Whit pecify:	White
hours hatur	olete		15. Decedent	Year or I t's Education at grade complete		16a. Deced						16b. Kind	d of Business	
T21;	mo	Elementary/Secon		1	1-4 or 5+)	life. DO	oind of wor NOT use		inng most	OF WORK	ng	Otem	HOme	
Id 2	Be	12 17. Father's Name (Fir	rst, Middle, La	ast)		Homer	maker_		18. Mothe	er's Name	e (First, Middle,			
Maryland 21215-0036 2 should be filed within 72 hours after death with the Maryland th and Mental Hygiene. 27 is marked other than "natural", or items 23a or 28a-f sho traumatic event, the Medical Examiner must be notified at	욘	Johr	n Wood							unk	Fergu	sson		
ore, Marylai 11 and 2 should be of Health and Ment fitem 27 is marked r other traumatic e		19a. Informant's Nam					-				Route Number	-		p Code)
		20a. Method of Dispo	sition		20b.	Place of Dispos	sition (Nam	e of			ldywше, .		ation - City or	Town, State
Saltimore, bermit. Page 1 and Department of Hea mportant: If item any injury or other		1 L▲Burial 2 L 4 □ Donation 5		3 Removal from Recify)		cemetery, crem aryland	Vetera	ns Cen	neterv	3-2	6-2012	Che1t	enham.	MD
Baltimo		21. Signature of Fune	ral Service Li	L M	0015	3 22	Name and	d Address	of Facility	Lee	Funeral MD 2073	Home,Ir 5	nc 6633	Old Alexandria
		23a. Part 1. Enter the shock, or heart	disease, or of failure. List or	complications that	caused the dea	th. Do not ente								Approximate Interval Between
⊸ Ph∫sician/		Immediate Cause (Findisease or condition resulting in death)	nal	a. En	ditag	e Pul	mer	wy	4 H	por	lenu	en		Onset and Death
Examiner			1	Due to	(or as a conse	Mrc H	PAni	+ 1	ail	wil				
1 7 %	niner	Sequentially list cond if any, leading to imm cause. Enter Underly	nediate ing	b. Due to	(or as a consec	ruence of):	000 0	V	0000					
vecute Q	Examine	Cause (Disease or in that initiated events resulting in death) La		c. Due to	(or as a consec	uence of):								
ate be executed physician and the burial-transit	dical			d										
oo/o	/Mec	IF FEMALE:		23c If yes or	itcome of pregn	anov.								
death ce	Physician/Me	23b. Was decedent pring the past 12 months 1 Pres 2 Prince 2 Princ	opths?	1 Live	e Birth 2 □ Fet gnant at time of	al death 3	Ectopic p		•			23	d. Date of de Month	llivery Day Year
t the d	Phys	9 🗌 Unknown		9 Uni							1			
requires that the death certificate been signed by the attending p should be detached for use as	þ	Part II. Other signification	ant condition	is contributing to	death but not re	sulting in the ur	nderlying c	ause give	n in Part I					the cause of death?
w requi	Completed										24a. Was	an i	24b, Were au	rtopsy findings available
The law requires ate has been signage 2 should b	Com		-5-50 19								autor perfo 1 Yes	rmed?	death?	completion of cause of
VITAI ysician: s certific director,	Be	25. Was case referred examiner? 1 Yes 2		Hospital:				Other	ce of Deat		only one)			
OIV og Phys erthis neral d	te: To	27. Mann of Death		28a. Date	Inpatient 2 of injury oth, Day, Year)	28b. Time of		A Bc. Injury a	4 ∐ Nu		me 5 🗌 Resid 28d. Describe h			cify)
VISION or Attendin fler death. irector: Aft	Certificate:	2 Accident	5 ☐ Pending Investiga 6 ☐ Could no	ation	itri, Day, Tear)	injury	М	work?	′es 2 □	No				
tal or At rs after call Direct		4 Homicide	determin	and 28e. Plac	e of Injury - At h ling, etc. <i>(Specit</i>		et, factory,	office		1	28f. Location (S City or Tow		lumber or Ru	ral Route Number,
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Medical	(Check 2 ∟		Physician: To the aminer: On the ba	sis of examination	n and/or investi	gation, in m	ny opinion	, death oc	curred at	the time, date a	nd place, ar	nd due to the	cause(s) and manner stated.
To ti withi To ti			e of certifier	TI.				License r		57			igned (Monti	
b		30. Name and address	s of person w	ho completed cau	se of death (Iter	n 23a) (Type, Pr	rint)	ind	HZ'	Pro	ailn	itai	1.m	120735
Sta		31. Date filed (Month,	Day, Year)	32.	egistrar's Signa		4 9	160		1 11				
Registra	al	M#	R 21	2012 1/2	way	d. pa	ve					· <u> </u>		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Deat 3. Time of Death Physician/ Medical Facility Name (if not institution, give stre Examiner Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Hours (Month, Day, Year) Director 1 □ M 2 □**X**F 74 Sept. 23, 193 Wirginia or 28a-f show filed within 72 hours after death with the Maryland 10b. County 10c. City, Town or Location "natural", or items 23a or 28a-f sho 10d. Inside City Limits Director 1 X Yes 2 No MD N/A Baltimore 10e. Street and Number 10f. Zin Code 10g. Citizen of What Country? Funeral USA 1209 N. Dukeland St. 21216 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian Armed Forces Black, White, etc. Completed by Yes 2 No 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 Specify: Black If Yes Give 1 Yes 2 X No Specify: 3 Widowed 4 Divorced Year or Dates. 27 is marked other than "natur traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Baltimore City Schools Cafeteria Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Carrington Alonzo Moore Sadie 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) . Page 1 and 2 shament of Health a tant; If item 27 is Earl Butler (Son) 6215 Pilgrim Rd., Baltimore, MD 21214 other 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1 Department of Important: If it any injury or o 1 X Burial 2 Cremation 3 Removal from State Loudon Park Cemetery 3/23/12 Baltimore, Maryland 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Loudon Park Funeral Home 3620 Wilkens Ave., Baltimore, MD 21229 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause, n each line. Interval Between Immediate Cause (Final disease or condition Onset and Death Physician/ Medical resulting in death) Due to (or as a consequence) Examiner Sequentially list conditions, Due to for as a consequence of if any, leading to immediate cause. Enter Underlying Exami Cause (Disease or injury that initiated events resulting in death) Last the Hospital or Attending Physician; The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of): Physician/Medical P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) in the past 12 months?

1 Yes 2 No Ectopic pregnancy Pregnant at time of death Month Unknown ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. signed I d be det 23e. Did tobacco use contribute to the cause of death? þ Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an s certificate has build be build be build be build be build autopsy performed? Yes Division of Vital funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 X No ည 1 Inpatient 2 I ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural Accident 5 Pending work neral Director: A 2 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) within 24 hours a Medical 10 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated d title of certifie Month, Day, Year, of death (Item 23a) (Type, Print)

State Registrar

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 9:02 Ам L. Clark March 2012 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Clinton Southern Maryland Hospital Prince George's Social Security Numbe If Under 24 Hrs. 7. Age (In vrs. last hirthday) If Under 1 Year Birthplace (State or Foreign Country) **Funeral** 8 Date of Rirth Min (Month, Day, Year) 223-52-7281 Director 1 □ M 2 🗓 F 72 April 3 1939 North Carolina Usual Residence of Decedent 28a-f show 10a State with the Maryland Examiner must be notified at 10c. City, Town or Location Director MD Forestville Prince George's 1X Yes 2 □ No ō 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral "natural", or items 23a 6505 Penn Avenue, Apt # 202 20747 USA hours after death 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No
If Yes, Give 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black White etc 1 Never Married 2 Married 2 Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify Specify: Black Completed 3 X Widowed 4 Divorced Year or Dates Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) within 72 pernit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than 'any injury or other traumatic event, the Me Elementary/Secondary (0-12) 12th College (1-4 or 5+) Private Homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Wesley Pitt Mable Elizabeth Hill 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Tammy Jordan/ Daughter 4019 Haynes Street, NE, Apt#1, Washington, DC 20019 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 M Burial 2 Cremation 3 Removal from State Mt. Olivet Cemetery | 03/19/2012 4 Donation 5 Other (Specify) Washington, DC Signature of Funeral Service Licens 22. Name and Address of Facility J.B. Jenkins Funeral Home 7474 Landover Road, Landover, Maryland 20785 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause a peach line. 101/d.d Immediate Cause (Final Onset and Death 155ine Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) ²Examiner Sequentially list conditions if any, leading to immediate Examine Due to (or as a consequence or) if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events To the Hospital or Attending Physician; The law requires that the death certificate be executed burial-tran and Due to (or as a consequence of) resulting in death) Last attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 the use as IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Month Day Year Pregnant at time of death page 2 should be detached the g Unknown Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has performed? Yes 2 ☐ No 2 🗌 No 1 Yes ours after death.

eral Director: After this certifical filled in by the funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital 2 VN0 Other: ြုင 1 Yes 1 Inpatient 2 ER/Outpatient 3 I DOA 4 Nursing Home 5 Residence 6 Other (Specify 27. Manner of Death 28a. Date of injury Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) Natural 5 Pendina work? 2 🗆 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined building, etc. (Specify) within 24 hours. To the Funeral I Medical 1 Sertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier completely 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 03/15/1 10 3

Registrar

State

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Day MARCH 2012 Year CARTER 9, 4:10 Рм Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death PRINCE GEORGE'S HOSPITAL PRINCE GEORGE'S CHEVERLY Social Security Number If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) **Funeral** 7. Age (In yrs. last birthday) 8. Date of Birth Min. (Month, Day, Year) Hours Director 578-19-8685 1 XM 2 □ F 21 5, 1990 WASHINGTON, DC MAY Usual Residence of Decedent 28a-f show 10a, State 10b. County 10c. City, Town or Location must be notified at Director 1 X Yes 2 No MARYLAND PRINCE GEORGE'S **GLENARDEN** 10e. Street and Number 10f. Zip Code 10a. Citizen of What Country? Funeral or items 23a 2947 HOBBLE BUSH COURT 20706 UNITED STATES death 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Examiner 1 X Never Married 2 Married 2 X No þ Page 1 and 2 should be filed within 72 hours after unent of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or Yes Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: 3 Divorced Specify: Completed BLACK Year or Dates other traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) DISABLED NONE Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ THOMPSON MARC KAREN CARTER 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) KAREN L. CARTER / MOTHER 2947 HOBBLE BUSH COURT, GLENARDEN, MARYLAND 20706 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date Department of H Important: If ite any injury or ot once. 1 XBurial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) RESURRECTION CEMETERY 3/19/2012 CLINTON, MARYLAND 21. Signature of Funeral Service Licensee 22. Name and Address of Facility JB JENKINS FUNERAL HOME, INC. 7474 LANDOVER ROAD, HYATTSVILLE, MARYLAND 20785 23a. Part 1. Enter the disease, or complications that caused shock, or heart failure. List only one cause on each line. or complications that caused the x atr., Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Immediate Cause (Final disease or condition resulting in death) Onset and Death Phylician 6 Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine burial-trar and Due to (or as a consequence of) attending physician Physician/Medical The law requires that the death certificate be Box 68760 use as the IF FEMALE 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No for Month Day Year Pregnant at time of death g Unknown P.O. signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 2 [No 3 Probably 4 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy perform certificate 2 No Yes To the Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one examiner? 1 Yes Other: 2 မ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) Director: After this 27 Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending 1 🗌 Yes hours after death Investigation 6 Could not be 2 No Accident filled in by the Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number 4 Homicide determined City or Town, State) within 24 hours a

To the Funeral C Medical 29a. Certifier Sertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 🗆 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and mann 29b. Signature and title of certifi 29d. Date signed erson who completed cause of death (Item 23a) (Type, Print) 30. Name and address of p 0 CATEVENIS 3001 HOSPITAL State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month March 2 0 1 2 KENDALL MARGARET COOKE 9:46 a Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Greater Baltimore Medical TOWSON Baltimore If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | Months | Day, Year | 2012 7. Age (In vrs. last birthday) **Funeral** 9. Birthplace (State or Foreign 1 🗆 M 2 💢 F Maryland Director N/A Usual Residence of Decedent 28a-f shov 10a. State 10b. County traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director Maryland Baltimore County Owings Mills 1 Yes 2 No 10e. Street and Number items 23a or 10f. Zip Code 10g. Citizen of What Country? Funeral 21117 USA 9407 Plane Tree Circle #206 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Was Decedent Even Armed Forces? 1 ☐ Yes 2 🎇 No Black, White, etc. African ò 9 1 X Never Married 2 ☐ Married If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: than "natural", 3 Widowed 4 Divorced Completed American 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry Baltimore, Maryland 21215 (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) permit. Page 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other that any injury or other traumatic event, the Mone. N/A N/A N/A N/A Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Jacqueline Rubambe Anthony Cooke 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9110 Abigail Drive, #1C, Rosedale, Maryland 21237 Nicholas Ngugi (Friend) 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State Dul. Valley Mem Grdns 3/24/2012 Timonium, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signat Withunga S rvi MITCHELL WIEDEFELD FUNERAL HOME, INC Maryland 21212 6500 York Road, Baltimore, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Physician/ ARDIORESPICATORY disease or condition Medical resulting in death) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events Examine or Attending Physician: The law requires that the death certificate be executed and Due to (or as a consequence of resulting in death) Last attending physician for use as the buria Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months? Day Year the 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by RESPIRATORY DISTRESS 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown 24a. Was an 24b. Were autopsy findings available within 24 hours after death.

To the Funeral Director: After this certificate has I completed filled in by the funeral director, page 2 s prior to completion of cause of death? performed 2 1 No 2 4 No 1 Yes Yes 25. Was case referred to medical 26. Place of Death (Check only one) Certificate: To Be Hospital 2 No 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Natural 2 Accid 28d. Describe how injury occurred 5 Pending 1 Yes 2 No ☐ Accident ☐ Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 🗌 Homicide determined City or Town, State) within 24 hours Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month. Day, Year) Pave no D0046156 NEON ATOLOGIST MARCH 15,2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Maria Pane, MD, 6701 N. Charles Street, Baltimore, Maryland 21204 32. Registrar's Signature State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend #27 Per ME G925 3/21/2012 JH
State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 10:52 PM 101 2012 Medical 4a. Facility Name (if not institution, give street and number) County of Death **Examiner** Montgmen

9. Birthplace (State ations of 1 Year If Under 24 Hrs. 8. Date of Birth State of Foreign Age (In yrs. last birthday) **Funeral** Director 1 AM 2 - F 1942 Banglad 28a-f show at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Director Examiner must be notified Rockville 1 XYes 2 No Md. Montgomery 10e. Street and Number ö 10f. Zip Code 10g. Citizen of What Country? items 23a 20852 Bangladesh 12014 Montrose Village Terr. 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates. Black, White, etc ō 1 Never Married 2 X Married þ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🕱 No Specify: Asian "natural", 3 Widowed 4 Divorced Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) I Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) Diplomat Ambassador and Mental Hygie is marked other Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Gyassuddin Ahmed Khatun Ahmed 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20852 Department of Health ar Important: If item 27 is any injury or Attach Nafees Chowdhury - Son 12014 Montrose Village Terr, Rockville, Md. 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State George Wash.Cemet: 3-18-12 4 ☐ Donation 5 ☐ Other (Specify) Adelphi, Md. 411kennedy st, N.W. re of Funeral Service Licensee 22. Name and Address of Facility Universal Mortuary Inc, Wash, D.C. 20011 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final nset and Death Pnysician/ disease or condition resulting in death) Medical Examiner Securitizity list conditions Examine Due to (or as a consequence of) if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events m_0 burial-transi Due to (or as a consequence of resulting in death) Last Physician/Medical 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

5 Other (specify) IF FEMALE 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? Month Day signed by the at d be detached for 1 Yes 2 No 9 Unknown Unknown P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? þ Records, 1

Yes 2

No 3

Probably 4

Unknown Completed 24b. Were autopsy findings available prior to completion of cause of autopsy perform death? 2 No Yes Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 Anpatient 2 ER/Outpatient 3 DOA HOLUDHUR funeral Division of 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28c. Injury at 28b. Time of Certificate: 28d. Describe how Injury occurred injury Accident 5 Pending 1 ☐ Yes 2 No Fe // within 24 hours after death To the Funeral Director: A filled in by the Investigation 6 Could not be Mas 17 2012 1027 3 ☐ Suicide 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Home Rockville my 20852 Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Certifying Nurse Practitioner: To the best of my knowledge, death occur red at the time, date and place, and due to the cause(s) and manner as stated PD 04344 State Registrar

DHMH 17 Rev 06-2011

171180

				nd / Department of Health and M	ental Hygie	ne
			T — State Registrar 1. Decedent's Name (First, Middle, Last)	Certificate of Death	Reg.	No. 2012 18775
-4	Physicia Medi		EMOLY	Collins	2. Date of Death	Day 2 Year OOZ M
-	Examir	ner	4a. Facility Name (if not institution, give street and number) The Johns Hopking (Hopp	tal Balh more	City	4c. County of Death
	Funeral Director		5. Social Security Number 216-40-4507 Usual Residence of Decedent 6. Sex 7. Age (In yls. In the second s	Ast birthday) If Under 1 Year If Under 24 Hrs. Months Days Hours Min. Yrs.	8. Date of Birth (Month, Day, Yea July II,	9. Birthplace (State or Foreign Country) Maryland
	yland -f show ed at	ctor	10a. State 10b. County 10c. Cit	ty, Town or Location		10d. Inside City Limits
	or 28a	Director	MD Baltimore	Dundalk 10f. Zip Code	10-	1 Yes 2 No Citizen of What Country?
	with t	Funeral	831 Jaydee Avenue	21222	Tog.	USA
980	1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at		If Ves Give	S. 13. Was Decedent of Hispanic Origin? (Spec If Yes, specify Cuban, Mexican, Puerto R	ify Yes or No- lican, etc.)	14. Race - American Indian, Black, White, etc. Specify: White
21215-0036	nin 72 hour ne. .han "natur e Medical	Completed by	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+)	16a. Decedent's Usual Occupation (Give kind of work done during most of workin, life. DO NOT use retired)	g 16b	b. Kind of Business/Industry
27	ed within Hygiene. other tha	Be C	12 2 17. Father's Name (First, Middle, Last)	engineer		US Army
Maryland	ld be filed Mental Hy arked oth atic event	To	Emory Gilbert Collins	Betty Le	(First, Middle, Maide ee Ruark	en Surname)
, Mar	and 2 shou Health and tem 27 is m		19a. Informant's Name/Relationship (Type, Print) Diane T. Collins — wife	19b. Mailing Address (Street and Number or Rural 831 Jaydee Ave; Dunda	Route Number, City	or Town, State, Zip Code) 1222
Baltimore,	Page nent c ant: If iry or			Place of Disposition (Name of Dispension) Dispension (Name of Dispension) Place (Name of Dispension)	ate 20c	Location - City or Town, State
Balt	permit. Departn Importa any inju		21. Signature of David Service Licensee Wade Directo	r 22. Name and Address of FacilityStat		
	⊺h, sician/		23a. Aart 1. Enter the disease, or complications that caused the death shock, or heart failure. List only one cause on each line. Immediate Sause (Final disease or condition	h. Do not enter the mode of dying, such as cardiac or	respiratory arrest,	Approximate Interval Between Onset and Death
The same of the sa	Medical Examiner		resulting in death) Due t (or as a consequence of the consequence of			
	ed nsit	miner	Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury	sense of		
0	ate be executed obysician and the burial-transit	dical Examiner	that initiated events resulting in death) Last C. Due to (or as a consequ	uence of):		
3760	ficate t g phys as the	Medi	d			
. Box 687	ie death certificate be executed the attending physician and ched for use as the burial-transi	Physician/Me	F FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown 23c. If yes, outcome of pregnant 1 ☐ Live Birth 2 ☐ Feta 4 ☐ Pregnant at time of do 9 ☐ Unknown	Il death 3 Ectopic pregnancy		23d. Date of delivery Month Day Year
ls, P.O.	To the Hospital or Attending Physician: The law requires that the deal within 24 hours after death. To the Funeral Director: After this certificate has been signed by the at completely filled in by the funeral director, page 2 should be detached to	by	Part II. Other significant conditions contributing to death but not resu	ulting in the underlying cause given in Part I.	23e. Did tobacc	o use contribute to the cause of death? 2 □ No 3 ☑ Probably 4 □ Unknown
Division of Vital Records,	ting Physician: The law requires h. After this certificate has been siç funeral director, page 2 should t	Completed			24a. Was an autopsy performed	24b. Were autopsy findings available prior to completion of cause of death?
E	tian: T ertifica ector, p		25. Was case referred to medical examiner?	26. Place of Death (Check of	1 Yes 2 I	No 1 Yes 2 No
Ž	Physic this corral dire	유	1 Ves 2 No Hospital: 1 Inpatient 2	Oak Time of		6 Other (Specify)
o uo	ending eath. rr: After he fune	Certificate:	1 Matural 5 Pending (Month, Day, Year) 2 Accident Investigation	28b. Time of 28c. Injury at work? M 1 ☐ Yes 2 ☐ No 28	d. Describe how inj	ury occurred
Divisi	tal or Atter safter de al Directo ed in by t		3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e. Place of Injury - At hor building, etc. (Specify)	me, farm, street, factory, office	3f. Location (Street a City or Town, Sta	and Number or Rural Route Number, te)
	the Hospi in 24 hou the Funer ipletely fill	Medical	only one) 3 Certifying Nurse Practitioner: To the best of m	edge, death occurred at the time, date and place, and a and/or investigation, in my opinion, death occurred at the ny knowledge, death occurred at the time, date and place	ne time date and pla	ce and due to the cause(s) and manner stated
	vitl Con		29b. Signature and title of certifier	29c. License number RES-000	A . A	Pate signed (Month, Day, Year) Y Ch 14, 2012
13	2+1		30. Name and address of person who completed cause of death (Item	23a) (Type, Print) D N, Wolfe St. Be		
	Stat Registra	_	31. Date filed (Month, Day, Year) NAR 2 1 2012			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year Angelo Charles Chiazza March 2012 10:30 PM 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 810 Hurley Court Harford 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 1 ▼ M 2 □ F Months Days Hours Min onth, Day, Year) 05/07/1923 West Virginia Yrs 235-20-7125 88 Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 X Yes 2 No Harford Bel Air 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 810 Hurley Court 21014 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces? 1 X Yes 2 No If Yes, Give Year or Dates. Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 🌠 No Specify: Specify. 3 X Widowed 4 Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working 16b. Kind of Business Industry life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 12 **Business Owner** Food / Service 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname)

Giuseppa D'Amico

20c. Location - City or Town, State

Beltsville, MD

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

Date

3/20/2012

810 Hurley Court, Bel Air, MD 21014

permit. Page 1 and 2 should be filed within 72 hours after death with the Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or amy injury or other traumatic event, the Medical Examiner must be 1 once.

For State Registrar

10a. State

MD

19a. Informant's Name/Relationship (Type, Print)

4 Donation 5 Other (Specify)

21 Signature of Funeral Service Licensee

20a. Method of Disposition

Toni Chiazza DiBlasi / Daughter

1 Burial 2 X Cremation 3 Removal from State

Paolo Chiazza

Physician/

Medical

Examiner

Funeral

Director

or 28a-f show notified at

ò

Director

Funeral

þ

Completed

Be

ည

Page 1 and 2 should be filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

Ph_sician/ Medical Examiner

sician and burial-transit anding physician use as the burial To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physicis use atten for u signed by the a page 2 s funeral director, within 24 hours after death.

To the Funeral Director: Af
completed filled in by the fu

Division of Vital Records, P.O. Box 68760

State

shock, or heart failure. List or Immediate Cause (Final disease or condition	complications that caused the deally one cause on each line. Congestive Hear		ode of dying, such as cardiac	or respiratory arrest,		Approximate Interval Between Onset and Death
Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events resulting in death) Last	b. Severe aortic Ste Due to lor as a consec C. Senile Dementia Due to (or as a consec d.	enosis Luence of				
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome of pregn 1 Live Birth 2 Fe 4 Pregnant at time of 9 Unknown	c pregnancy (specify)	cy 23d. Date of o			
Part II. Other significant conditio	is contributing to death but not re	sulting in the underlyin	g cause given in Part I.		2 No 3 Pr 24b. Were aut prior to c death?	the cause of death? obably 4 Unknow opsy findings available completion of cause of 2 No
25. Was case referred to medical examiner?			26. Place of Death (Chec	ck only one)		
		1				fy)
1 Yes 2 No 27. Manner of Death 1. Natural 5 Pendin, 2 Accident Investig	(Month, Day, Year)					
1 ☐ Yes 2 🔀 No 27. Manner of Death 1 💆 Natural 5 ☐ Pending	(Month, Day, Year) ation of be	M nome, farm, street, facto	1 🗌 Yes 2 🗌 No	28f. Location (Street City or Town, St		al Route Number,
27. Manner of Death 1. Natural 2	(Month, Day, Year) ation of be 28e. Place of Injury - At h	M nome, farm, street, factor fy) wledge, death occured on and/or investigation, in	1 Yes 2 No ory, office at the time, date and place, a in my opinion, death occurred	City or Town, Standard due to the cause(s) at the time, date and plant	and manner as sta	ted. ause(s) and manner sta

20b. Place of Disposition (Name of

cemetery, crematory or other place,

Chesapeake Crematory

22 Name and Address of Facility

Registrar

31. Date filed (Month, Day, Year)

MAR 2 1 2012

racked

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Paul Raymond Ciccone March 18³ 20°72 4:20 A M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Frederick College View Center Fredrick Social Security Number If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) If Under 1 Year **Funeral** X 1 □ M 2 □ F Days Hours Min (Month 2 Day 1 Year) New Jersey 216-72-9386 50 Director Yrs Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits must be notified at Director Yes 2 No Carroll Westminster ō 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? . 23a Funeral 750 Warfieldsburg Road 21157 USA iral", or items ? death v 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2X No If Yes, Give Year or Dates. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. . Or þ 1 Never Married 2X Married Baltimore, Maryland 21215-0036 Page 1 and 2 should be filed within 72 hours after 1 Yes 2 No Specify. 'natural", Specify: Completed 3 Widowed 4 Divorced White Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical I 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Master Woodworker 12 Carpentry Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Raymond Ciccone Sarah Mchale 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2114 Bollinger Mill Road, Finksburg, MD 21048 Joseph Dominic Ciccone / Brother 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State ☐ Burial 2 Cremation 3 ☐ Removal from State Chesapeake Crematory 3/20/2012 Beltsville, MD 4 Donation 5 Other (Specify) 21. Signature of Funeral Sen 22. Name and Address of Facility Dorota Marshall Maryland Cremation Services, PO Box 1413 Baltimore, MD 21203 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Vrhusi disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) burial-transit Cause (Disease or injury that initiated events Due to (or as a consequence of): resulting in death) Last attending physician for use as the buria Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 5 Other (specify) in the past 12 months? be detached for Month Day Year Pregnant at time of death the 9 Unknown g Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 ☐ Probably 4 ☐ Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of 24a. Was an this certificate has autopsy death? 2 No 1 🗌 Yes Yes the funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital 2 TYNo Other: ၀ 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred injury **▼** Natural 5 Pending 1 ☐ Yes 2 ☐ No 24 hours after death. Funeral Director: A Investigation Accident 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, filled in by determined City or Town, State Medical 💆 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated within 2. only one) 29b. Signature and title of certifier 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year)

State

Registrar

2012

			Ci-i-	partment of Health and Mertificate of Death	,	giene	08778
	Physicia		1. Decedent's Name (First, Middle, Last) Donald Eugene Craig		2. Date of Dea Month March		3. Time of Death 6:45A M
	Medio Examin		4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of Death	March	4c. County of Death	
			65 1/2 Liberty St.	Westminster		Carroll	
	Funeral Director		5. Social Security Number 228-92-3488 Usual Residence of Decedent 6. Sex	/ If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day) 7-14-1	Year) Count	lace (State or Foreign ry)
	aryland a-f shov fied at	Director	10a. State 10b. County 10c. City, Town or MD Carroll	Location Westminster		1	Od. Inside City Limits
	ith the M 23a or 28 st be noti	ral Dir	10e. Street and Number 65 1/2 Liberty St.	10f. Zip Code 21157		10g. Citizen of What Coun USA	
9	ge 1 and 2 should be filed within 72 hours after death with the Manyland it of Healih and Mental Hygiene. If the m 27 is marked other than "natural", or items 23a or 28a-f show if firem 27 is marked other than "natural", or items 25a or 28a-f show or other traumatic event, the Medical Examiner must be notified at	by Funeral I	11. Marital Status 1 □ Never Married 2 □ Married 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Yes 2 □ No	B. Was Decedent of Hispanic Origin? (Spe If Yes, specify Cuban, Mexican, Puerto I	cify Yes or No- Rican, etc.)	14. Race - America Black, White, e	
5-003	hours afi natural", dical Exa	Completed I		1 ☐ Yes 2 🖾 No Specify:	1	Specify: Whit	
2121	within 72 giene. er than " the Med,		Elementary/Secondary (0-12) College (1-4 or 5+) life.	e kind of work done during most of workii DO NOT use retired) gine Mechanic		Mechanic	,
Baltimore, Maryland 21215-0036	should be filed n and Mental Hy 7 is marked oth traumatic event	To Be	17. Father's Name (First, Middle, Last) Harry Craig Sr.	18. Mother's Name Acelia			
, Mar	and 2 shou Health and em 27 is m ther traum:	1	l	iling Address (Street and Number or Rural $f Box 2191$, Winc			′
more	Page 1 ar ment of He ant: If iter ury or oth		20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)	cosition (Name of ematory or other place) Carroll Crem 3/1	9/12	20c. Location - City or Too Sykesville	
Balt	permit. Page Department Important: I any injury o		21. Signature of Juneral Service Licensee	22. Name and Address of Facility Fle	tcher		
F	h _a sician		23a. Part 1. Enter the disease, or complications that caused the death. Do not en shock, or heart failure. List only one cause on each line.		r respiratory arre	st,	Approximate Interval Between Onset and Death
	Medical Examiner		Due to (or as a consequence oi):	Α	7,100,10		15 YEARS
	uted d ansit	Examiner	Gause (Disease or injury that initiated events Sequentially for conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events C.				
00	te be executed nysician and he burial-transit	dical Ex	resulting in death) Last Due to (or as a consequence of):				
	artificat ding ph se as th	/Mec	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy				
	requires that the death certificat been signed by the attending ph should be detached for use as the	Physician/Med	in the past 12 months?	☐ Ectopic pregnancy ☐ Other (specify)		23d. Date of deliver	y Day Year
	ires that the signed by the ld be detach	۵	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.		pacco use contribute to the	
Vital Records,	The law requires ate has been sign page 2 should b	Completed			24a. Was ar	24b. Were autop	sy findings available pletion of cause of
a a	lan: Ir rtificat ctor, pa		25. Was case referred to medical examiner?	26. Place of Death (Check	perform 1 Yes 2 only one)	No 1 Yes 2	? □ No
<u> </u>	hysic this ce al dire	၉	Yes 2 ☐ No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpati		ne 5 🗷 Reside	nce 6 Other (Specify)	
Division of	tending Figure 1 the funer.	Certificate:	27. Manner of Death 1	of 28c. Injury at work? M 1 □ Yes 2 No	8d. Describe ho	w injury occurred	
DIVIS	ital or At urs after c ral Direct illed in by		4 ☐ Homicide determined 28e. Place of Injury - At home, farm, s building, etc. (Specify)		City or Town		
:	to the Nospital or Attending Physician: The law within 24 hours after death. To the Funeral Director, After this certificate has completely filled in by the funeral director, page 2:	Medical	29a. Certifier (Check check only one) 1 ☐ Certifying Physician: To the best of my knowledge, death only one) 3 ☑ Certifying Nurse Practitioner: To the best of my knowledge, death only one)	stigation, in my opinion, death occurred at te, death occurred at the time, date and place	the time date and	diplace, and due to the caus	e(s) and manner stated
	C T wit		29b. Signature and title of certifier Hean CRNP	29c. License number ROW3707	29	9d. Date signed (Month, Di	ay, Year)
			30. Name and address of person who completed cause of death (Item 23a) (Type, JACQUELINE PHEARN CRNP 1689	Print) 3C Posle Rd Was	stmins	ler HD Zi	157
	State Registra	_	31. Date filed (Month, Day, Year) MAR 2 1 2012 33. Registrar's Signature	nes!			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene? Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Day MARCH 18, 2012 PHYLLIS COPELAND 12:40 PM Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death GILCHRIST HOSPICE CARE TOWSON BALTIMORE 5. Social Security Number **Funeral** 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Days Hours Country) 216-01-8201 **Director** 1 □ M 2 🔀 F 92 01/11/1920 MD Usual Residence of Decedent 28a-f show 10a. State the Maryland notified at Director 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 🗓 No MD BALTIMORE BALTIMORE 10e. Street and Number ō 10f. Zip Code 10g. Citizen of What Country? item 27 is marked other than "natural", or items 23a or other traumatic event, the Medical Examiner must be Funeral 1904 AUTUMN FROST LANE USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married 1 ☐ Yes 2 🗓 No If Yes, Give Baltimore, Maryland 21215-0036 permit. Page 1 and 2 should be filed within 72 hours after 1 ☐ Yes 2 X No Specify: 3 XWidowed 4 ☐ Divorced Specify. Completed Year or Dates WHITE 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4 or 5+) 12 HOMEMAKER OWN HOME Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, and Mental F မ JOSEPH MASK MOLLIE GILDEN 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is any injury or other trau BONNIE SCHLENKER/DAUGHTER 1904 AUTUMN FROST LANE, BALTIMORE, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 K Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) HAR SINAI CONGR. 03/20/2012 OWINGS MILLS, MD 21. Signature of Juneral Service 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 21208 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arre-Approximate Interval Between shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ nset and Deat disease or condition resulting in death) Medical **Examiner** Sequentially list conditions, it may leading to immediate cause. Enter Underlying Examine Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or injury physician and s the burial-trans that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 as for use 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of deliver 3 Ectopic pregnancy in the past 12 months? Pregnant at time of death Dav Year 5 Other (specify) g 🗌 Unknown by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an certificate has page 2 autopsy performe Yes 2 No funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? P 2 No 1 🗌 Inpatient 2 🗍 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Spec this 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural injury 5 Pending 1 Yes 2 No 2 Accident Investigation Suicide Could not be 3 ☐ Suicide
4 ☐ Homicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined within 24 hours a Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 29b. Signature and title of

DHMH 17 Rev 06-2011

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 201^{Year}_{2} MARCH 11 RICHARD DAVIS 1:20 P M 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death HARFORD FOREST HILL HEALTH AND REHABILITATION FOREST HILL If Unde 8. Date of Birth 9. Birthplace (State or Foreign Social Security Number 7. Age (In yrs. last birthday) Hours Month Day, Yea July 1947 Texas 461-74-5190 1**X** M 2 □ F 64 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1 Yes 2 No MD Harford Aberdeen 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21001 USA 180 Darlington Ave. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 1X Yes 2 \(\sum_{No} \) 1967-Black, White, etc. 1 Never Married 2 Married Specify: white 1 ☐ Yes 2 🛣 No Specify. 3 Widowed 4 Divorced 1983 Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 12 College (1-4 or 5+) computer operator government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Frida Peet Leland G. Peet 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 180 Darlington Ave; Aberdeen, MD 21001 Angela Davis - wife 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 22. Name and Address of Facility State Anatomy Board 655 W. Baltimore St: Baltimore, MD 21201 art 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, nock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final melaslate disease or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of):

To the Hospital or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760 thin 24 hours after death.
the Funeral Director: Af

Physician/

Medical

Examiner

Funeral

Director

28a-f show

items 23a or 28a-f sho ner must be notified at

or

'natural",

than

and Mental Hygie is marked other

Department of Health an Important: If item 27 is usual injury or other

Physician/

Medical

Examiner

physician s the burial

signed by det

has s certificate has director, page 2 Examine

Physician/Medical

þ

Completed

Be

Certificate: To

Medical

the Medical Examiner

injury or other traumatic event,

Director

Funeral

þ

Completed

Be

2

with the Maryland

within 72 hours after death

Baltimore, Maryland 21215-0036

IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23d. Date of delivery Month Day Year							
Part II. Other significant conditions	23e. Did tobacco use contribute to the cause of death?							
		1 Yes 2 No 3 Probably						
		24a. Was an autopsy performed? 1 \(\sum \) Yes 2 \(\sum \) No \(\) No \(\) No \(\) Yes 2 \(\sum \) No						
25. Was case referred to medical	26. Place of Death (Check only one)							
examiner? 1 Yes 2 No	Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home	5 Residence 6 Other (Specify)						
27. Manner of Death ↑ Natural 5 ☐ Pending 2 ☐ Accident Investigation	(Month, Day, Year) injury work? M 1 ☐ Yes 2 ☐ No	d. Describe how injury occurred						
3 ☐ Suicide 6 ☐ Could not 4 ☐ Homicide determined	28e Place of Injuny - At home form street factory office	8f. Location (Street and Number or Rural Route Number, City or Town, State)						
(Check 2 Medical Exar	vician: To the best of my knowledge, death occurred at the time, date and place, and onliner. On the basis of examination and/or investigation, in my opinion, death occurred at the see Practitioner: To the best of my knowledge, death occurred at the time, date and place,	e time, date and place, and due to the cause(s) and manner stated.						

29c. License number

032255

BEL

AIR, MD.

29d. Date signed (Month. Day, Year)

2012

MATZH 12,

21014

State Registrar DAVID DUNN

29b. Signature and title of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

within 2, To the F complet

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 0610 AM Physician/ 201 STRADA DIO Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** CROSS NER SPRING MONTGOMERY HOSPITA If Under 1 Year If Under 24 Hrs. Social Security Number 6. Sex 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** (Month, Day, Year) Hours 577-04-4560 1 ☑ M 2 □ F **Director** 70 UNK 28a-f show 10d. Inside City Limits 10b. County 10c. City, Town or Location ä Director Examiner must be notified 1 ✓ Yes 2 ☐ No WASH 1 RAINIER 10f. Zip Code 10g. Citizen of What Country? ō 10e. Street and Number 23a Funeral 2071 BLAND BHODB NNK items 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. 0. 1 Never Married 2 Married 1 Yes 2 No If Yes, Give Completed by Maryland 21215-0036 1 Yes 2 ☐ No Specify: UNK Specify: WHITE "natural", 3 Widowed 4 Divorced Year or Dates. traumatic event, the Medical 16a. Decedent's Usual Occupation unk (Give kind of work done during most of working life. DO NOT use retired) unk 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) and Mental Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) unk unk Be 18. Mother's Name (First, Middle, Maiden Surname) unk 17. Father's Name (First, Middle, Last) unk 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau FOREST GLBN CROSS HOSPITA 200 HOLY Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 State 21. Signature of Full - | Corvine 22. Name and Address of Facility State Anatomy Board Ronald Director 655 W. Baltimore St; Baltimore, MD 21201 art 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate or heart failure. List only one cause on each line Interval Between Onset and Death Physician/ ADVANCED IRRHOSI disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner & BATIC ENCEPHAI Sequentially list conditions if any, leading to immediate cause. Enter Underlying Exam Cause (Disease or injury that initiated events resulting in death) Last HUPOXIC RESPURATOR burial-trai Due to (or as a consequence of) attending physician Physician/Medical death certificate be 8 8 Box 68760 the as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) 4 ☐ Pregnant at time of death 9 ☐ Unknown signed by the at Id be detached f 9 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Vunknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an within 24 hours after death.

To the Funeral Director. After this certificate has autopsy performed 1 Yes 2 No Yes completely filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital. Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No ၉ 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 27. Mann of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: the Hospital or Attending Natural injury work? 5 Pending 2 🗌 No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 26 hmanic-D 663 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 06-2011

State Registrar 1200

FOREST

GLE N

RAHMANIAN

DR MAJ(D 31. Date filed (Month, Day, Year)

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 2012 March 3:50 Robert Earl Fisher Jr. Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Kent 20762 Bayside Avenue Rock Hall If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number 8. Date of Birth 7. Age (In yrs. last birthday) Funeral June 2, Hours Min. Pennsylvania Director 198-46-7357 58 1**X** M 2 □ F 10a. State 10c. City, Town or Location 10d. Inside City Limits the Maryland Director notified 28a-f 1 Yes 2 No MD Kent Rock Hall 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 0 must be Funeral 23a 20762 Bayside Ave. 21662 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) ral", or item 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Page 1 and 2 should be filed within 72 hours after white 1 Yes 2 X No Specify. Specify: "natural", Completed 3 Widowed 4 Divorced Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) Give kind of work done during most of working Hygiene. other than " life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) seafood industry commercial crabber Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental H ၉ Robert Earl Fisher Sr. Mary Anne Nucho 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20762 Bayside Ave; Rock Hall, MD 21662 19a. Informant's Name/Relationship (Type, Print) Elena Fisher - wife Health tem 27 other 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State o <u>∓</u> o ☐ Burial 2 ☐ Cremation 3 ☐ Removal from Stat Department of Important: If any injury or 5 Other (Specify) Funer 22. Name and Address of Facility State Anatomy Board 655 W. Baltimore St; Baltimore, MD 21201 Enter the disease, or complications that cause the death. Do not enter the mode of dying, or heart failure. List only one cause on east line. 23a. Part 1 al Retween Immediate Cause (Final Ph_sician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions Examine Due to lor as a consequence of cause. Enter Underlying Cause (Disease or injury g physician and as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Be Completed by Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 months? page 2 should be detached for 1 Yes 2 9 Unknown signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 No 1 Tyes 3 Probably 4 Unknown Were autopsy findings available prior to completion of cause of 24a. Was an autopsy death? 1 Yes ☐ Yes 25. Was case referred to 26. Place of Death (Check only one) examiner' Hospital ၉ 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA of Death 28a. Date of injury 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) iniun work?
1 \[\text{Yes} 2 \[\text{No} \] Natural 5 Pending s after death. Accident Investigation the Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined 24 hours a Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated sis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Ce within 2 Mying Nurse Practitione nly one) Signature and title 29d. Date signed (Month. Day, Year) ame and address of person who completed cause of death (Item 23a) (Type, Print) Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1, Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 3 Physician/ Year Goldic Fritz 2044 M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner UMMC Baltimore If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Social Security Number 7. Age (In yrs. last birthday) 8 Date of Birth **Funeral** 218-54-0226 Days (Month, Day, Year) Director 1 🗆 M 2 🗷 F 60 1952 MD and Mental Hygiene. is marked other than "natural", or items 23a or 28a-f show aumatic event, the Medical Examiner must be notified at 10d. Inside City Limits 10c. City, Town or Location Director HAMPSTEAD 1 Yes 2 No ARROLL 10e. Street and Number 10g. Citizen of What Country? Funeral BRODBECK RD., 21074 USA 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black White etc. 1 ☐ Yes 2 No If Yes, Give 1 Never Married 2 Married Completed by 3altimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify Specify: WHITE 3 Divorced Year or Dates 16a. Decedent's Usual Occupation Decedent's Education 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) BUILDING NSPECTOR Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be.
Department of Health and Mental Important: If item 27 is mariany injury or other. ဂ္ HANSBOROUGH DEARL 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) SMITH-DAVGHTER RD, WALNUT COVE, NC 1613 FAGG 20a. Method of Disposition 20b. Place of Disposition (Name of Date 1 Burial 2 Cremation 3 Removal from State cemetery, crematory or other pr CREM SYKESYILLE, MID 3-20-2012 4 ☐ Donation 5 ☐ Other (Specify) Funeral Service Licens FUNERAL HOME, WESTMINSTER, MD titeln. ETCHER 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph_sician/ Sepsis to Klebsiella bacterer Secondary disease or condition Medical resulting in death) tdays Due to (or as a consequence of): Examiner respiratory Sequentially list conditions, Examiner Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Cause (Disease or injury by the attending physician and etached for use as the burial-tran that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical the Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: detached for use 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 mon Month Dav Vear 1 Yes 2 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e, Did tobacco use contribute to the cause of death? Be Completed by 2 ☑ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed? this certificate has filled in by the funeral director, page 2 death? 2 No 1 Yes Yes 25. Was case referred to medical examiner?
1 ☐ Yes 2 ☐ No 26. Place of Death (Check only one) Hospital Other: 2 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? s after death. Certificate: 28d. Describe how injury occurred 1 Natural 5 Pending 1 Yes 2 No 2 Accident Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined within 24 hours a

To the Funeral I

completely filled Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 29b. Signature and title of certific AU4176435A100777 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 06-2011

State Registrar 5.

Greene

Makker, MD

George

MAR 2 1 201

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Phillip Eugene Farnschlader 2012 Medical march 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Har fore tizens Nursing Home brace 8. Date of Birth 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** XXM 2 \square F 74 Hours 07/30/1937 **Director** Pennsylvania 208-28-0473 Usual Residence of Decedent 28a-f show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f shon any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1XXYes 2 No Harford Aberdeen Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 700 West BelAir Avenue, Apt. 101 21001 USA 12. Was Decedent Ever in U.S. Armed Forces?

**XX Yes 2 \(\times \) No 1957— Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black, White, etc. à 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates. 1 ☐ Yes 2 X No Specify: Specify: white Completed 3 Divorced 4 Divorced 1977 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 12 U.S. Government Military 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Dorothy Keninger Karl Farnschlader 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 700 West BelAir Avenue Apt. 101, Aberdeen, MD 21001 Farnschlader (wife) 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) R.A.Ferris & Company 03/21/2012 West Chester, PA 22. Name and Address of Facility Tarring-Cargo Funeral Home, P.A. 21. Signature of Funeral Service Nicensee Maryland 21001 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a Examiner Sequentiary list countries, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine attending physician and for use as the burial-transit that initiated events resulting in death) Last Due to (or as a co Physician/Medical P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? b the Hospital or Attending Physician: The law equires 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Division of Vital Records, Completed Were autopsy findings available prior to completion of cause of autopsy death? 1 🗌 Yes 25. W s case ref rred to edical Be 26. Place of Death (Check only one) Hospital: 2 No Other: 1 \(\text{ Y6} 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Man r of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending 1 Yes 2 No 2 Accident
3 Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Gertifying Nurse Practioner: To the Sest of my knowledge, death conured at the limit 29b. Signatur 29d. Date signed (Month, Day, Year) Sus of person who completed cause of death/(Item 23a) (Type, Print) 32. Registrar's State Registrar

Phillip

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Deatl 3. Time of Death Physician/ amy Medical 4a. Facility Name (if ot institution, give street and number) 4b. City, Town, or Location of Death **Examiner** County of Death BALTIMORE SLADE AVENUE, #806 BALTIMORE If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. **Funeral** Social Security Numbe Sex 7. Age (In yrs. last birthday, 8. Date of Birth 9. Birthplace (State or Foreign 02/22/1921 Country) **Director** 91 MD 213**-**14**-**4794 Usual Residence of Decedent or 28a-f show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f shot any injury or other traumatic event, the Medical Examiner must he morified at injury or other traumatic event, the Medical Examiner must he morified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 X No MD BALTIMORE BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral SLADE AVENUE, #806 21208 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 11. Marital Status 14. Race - American Indian Armed Forces? 14 Yes 2 ☐ No Black, White, etc. Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 XNo Specify. If Yes, Give 3 X Widowed 4 Divorced WHITE Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) GLENN L. MARTIN Elementary/Seconday (0-12) College (1-4 or 5+) 12 TOOL MAKER AIRCRAFT COMPANY Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ JOSEPH FELDSTEIN IDA ROSENBLATT 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) SLADE AVENUE, #806, BALTIMORE, MD JEROME FELDSTEIN/SON 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place, 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) HEBREW ORTHODOX CEM 03/19/2012 BALTIMORE, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD, PIKESVILLE, MD Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause in each line. 23a. Part 1. Enter 1 Immediate Cause (Final Onset and Death Ph_sician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, Due to (or as a cor sequence of) if any, leading to immedicause. Enter Underlying Examin Cause (Disease or iinjury that initiated events resulting in death) Last the burial-tran Due to (or as a consequence of) attending physician Physician/Medical or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregna 5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No detached for Month Dav Year 9 Unknown signed by the detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an within 24 hours after death. To the Funeral Director, After this certificate has I completed filled in by the funeral director, page 2 ϵ autopsy perform death? 2 No Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 X No Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 Natural 5 Pending work? injury 2 🗌 No Accident Investigation 6 Could not be Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide the Hospital Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title 29d. Date signed (2212 State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registra Certificate of Death 3. Time of Death OSEPH 2. Date of Death FRIEDMAN. Physician/ γear Month 9.30t Medical 4a. Facility Name (if not institution, give street and number) City, Town, or Location of Death 4c. County of Death Examiner N/A Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs. Birthplac Country) MD 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days 1 X M 2 - F Months Hours Min 07/27/1915 96 Yrs **Director** 218-07-8820 Usual Residence of Decedent 28a-f shov "natural", or Items 23a or 28a-f sho edical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 No MD N/A BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral with 3900 LOCH RAVEN BLVD 21218 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian Armed Forces?
1 X Yes 2 □ No If Yes, specify Cuban, Mexican, Puerto Rican, etc. Black, White, etc. Completed by 1 Never Married 2 Married Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: Specify: WHITE 3 X Widowed 4 Divorced event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) than " Elementary/Seconday (0-12) College (1-4 or 5+) and Mental Hygiene. SALESMAN CLOTHING is marked other Be permit. Page 1 and 2 should be filed Department of Heatth and Mental Hy Important: If item 27 is marked oth any injury or other traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 ISRAEL FRIEDMAN IDA 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 10 COACHMONT COURT, BALTIMORE, MD 21209 MARK K FRIEDMAN / SON Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State BNAI JACOB CEMETERY 4 Donation 5 Other (Specify) 03/18/2012 BALTIMORE, MD 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 21208 23a. Part 1. Enter the shock, or heart fai sease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, illure. List only one cause on each line. RREST Immediate Cause ARDIAC Onset and Death Physician. disease or condition Medical resulting in death) Due to (or as a consequence of): ARTERY DISEASE Examiner CORONARY Sequentially list conditions, in any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence or Hospital or Attending Physician; The law requires that the death certificate be executed use as the burial-transi and that initiated events resulting in death) Last Due to (or as a consequence of): the attending physician Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy for in the past 12 months?
1 Yes 2 No Month Day Year 4 Pregnant 5 Other (specify) Pregnant at time of death hed q 🗌 Unknown P.O. detach ned by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by cate has been signe page 2 should be Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🗷 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy performe 2 No Yes 2 N 1 Yes in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 🕅 No 1 🗌 Yes မ 1 🖾 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred injury 1 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No Accident
Suicide Investigation within 24 hours after deat To the Funeral Director: 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined completed filled Medical 29a. Certifier 1 🖊 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License numbe MI) 039000 E am

DHMH 17 Rev 7/2009

State Registrar 5900

31. Date filed (Month. Dav. Teal

LOC

MY

BALTIMORE

30. Name and address of person who completed cause of death (item 23a) (Type, Print)

Amend PII 27,28a-f, per ME G9356 1/4/13 TRT
State of Maryland / Department of Health and Mental Hygiene

Amend #28a,28d,per me,g937 3-28-13 sm
Reg. No. 2 1 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month ANNIE GANTT 10:09 Medical Jarch 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death DOCTORS HOSPITAL LANHAM PRINCE GEORGE'S Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign JAN 14 1920 SOUTH CAROLINA Director 215-24-4031 1 □ M 2 □**X** 92 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location the Maryland 10d. Inside City Limits Director notified 28a-f 1 X Yes 2 No PRINCE GEORGE'S MD BOWIE 10e. Street and Number ò 10f. Zip Code 10g. Citizen of What Country? ms 23a or must be Funeral 3715 BASKERVILLE DRIVE 20721 USA 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, "natural", or ite Armed Forces?

1 Yes 2 XNo
If Yes, Give
Year or Dates. Black, White, etc þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: Specify: BLACK Completed 3 ₩ Widowed 4 Divorced the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 12TH POSTAL WORKER artment of Health and Mental Hygie ortant: If item 27 is marked other injury or other traumatic event, the GOVERNMENT Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ LAWRENCE BRYANT LULA HAYES 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is any injury or other trau LOUISE BROWN/DGT. 3715 BASKERVILLE DRIVE BOWIE, MARYLAND 20721 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Page 1 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State HARMONY CEMETERY 3/20/2012 LANDOVER, MARYLAND ☐ Donation 5 ☐ Other (Specify) e of Functal Service 22. Name and Address of Facility J. B. JENKINS FUNERAL HOME, INC. 7474 LANDOVER ROAD HYATTSVILLE, MARYLAND 20785 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Opeet and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner ERTIFICATIO POPROVED BY MEDICAL EXAMINER ongestive Sequentially list conditions, or as a consequence of): if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Exami burial-transi attending physician and for use as the burial-tran Due to (or as a consequence of) resulting in death) Last Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 month Dav Pregnant at time of death signed by the ard d be detached for 9 Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 3 Division of Vital Records. 1 Yes 2 No 3 Probably 4 Unknown Head Injuries Completed Were autopsy findings available prior to completion of cause of 24a. Was an has page 2 autopsy death? certificate 1 ☐ Yes 2 ☐ No Yes To the Hospital or Attending Physician: funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) xamino? Hospital 2 No Other: မ 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify) within 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral di 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d Describe how injury occurred fell at home Multiple Falls work? Natural 5 Pending injury XAccident 2012 ₁₋₃₁₋₁₂ 2 **X**No Investigation 6 Could not be unk Suicide 3 ☐ Suiciae 4 ☐ Homicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Home 3715 Baskerville Dr Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 3/13/12 MDD71459 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend 1tem 31 per dvr g925 3-21-12 vt State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 14541 M Roseanne Marie Green MARC 2012 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death . Regional Median Mamia 544130414 If Under 1 Year If Under 24 Kirs 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** May 12, 1943 Maryland Director 233-70-9074 68 1 🗆 M 2 💢 F Usual Residence of Decedent ms 23a or 28a-f show must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 □ No MD Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral within 72 hours after death with 603 S. Ann Street #304 21231 USA items 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. traumatic event, the Medical Examiner Armed Forces Black, White, etc. ō þ 1 Never Married 2 Married 1 ☐ Yes 2 X No If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: white "natural", Specify: 3 Widowed 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) filed within 72 tal Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) 8 0 waitress food industry Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) should be file and Mental H is marked o ည James Bosley Hildebrand Mary Eleamor Cropsey 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 st Department of Health a Important: If item 27 is any injury or other tra 12513 Eastern Ave; Baltimore, MD 21220 Ernest Green - son 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4
☐ Donation 5 ☐ Other (Specify) Sign, wre of Funeral Service Licens 22. Name and Address of Facility State Anatomy Board 655 W. Baltimore St; Baltimore, MD 21201 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Ph_sician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of): Cause (Disease or Injury that initiated events and trar Due to (or as a consequence of): resulting in death) Last attending physician a for use as the burial Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Box 68760 IF FEMALE: yes, outcome of pregnancy
Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months? Dav Pregnant at time of death Yes 2 No ed by the a g Unknown Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by DIAbetes Division of Vital Records, Completed 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available has autopsy performed? Yes 2 **X** No prior to completion of cause of death? certificate director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: 2 🔀 No မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 X DOA 4 Nursing Home 5 Residence 6 Other (Specify) After this 24 hours after death.

Funeral Director: After this letely filled in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred work?
1 Yes 2 No 1 🛮 Natural 5 Pending injury Accident
Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical

State Registrar

29b. Signature and title of certifier

29a. Certifier

only one)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DR. LEI GONG

MD 21863

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

within 2

1 💆 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene
Amend item # 11,12,13,14,120,20b, 20c, and22 per ph Film#G960
Reg. No. 7 1. Decedent's Name (First, Middle, Last, 2. Date of Death 3. Time of Death Month Physician/ AVID GOODM AN 2017 10.18A.M Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death **Examiner** 4b. City, Town, or Location of Death Good Samaritan Hospital Raltimore 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Dec 29, Months Hours Min. Maryland Director 30 212-02-6685 Usual Residence of Decedent 28a-f shov 10a, State 10c. City. Town or Location 10d. Inside City Limits injury or other traumatic event, the Medical Examiner must be notified at Director 1 Ves 2 No MD Parkville Baltimore 10e. Street and Number 10f. Zip Code 23a or 10g. Citizen of What Country? Funeral 21234 USA 7033 McLean Blvd. items 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status - Unic 14. Race - American Indian, Armed Forces? unk Black, White, etc. ģ 1 Never Married 2 Married ò Baltimore, Maryland 21215-0036 1 ☐ Yes 2 👿 No Specify: If Yes, Give Year or Dates Specify: Black "natural", 3 Widowed 4 X Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) 12 cab driver transporation Be 17. Father's Name (First, Middle, Last, 18. Mother's Name (First, Middle, Maiden Surname) ပ David Goodman Marian Sample 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 st Department of Health a Important: If item 27 is any injury or other terms 3421 Dudley Ave; Baltimore, MD 21213 Davina Goodman - sister 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place, 1 Burial 2 X Cremation 3 Removal from State 3-22-2012 Baltinore, MD Crematory State-Anatomy-Beard Joseph H. Ronal W 22. Name and Address of Facility 655-W--Baltimore-St;-Baltimore,-MD-21201 2140 N. Fulton Ave Baltimore, MD 21017
The mode of dying, such as cardiac or respiratory arrest,

Approximate Interval Between Part Enter the disease, or complications that caused the death. Do not enter shock or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final 0 5 Physician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine Due to (or as a consequence of) attending physician and for use as the burial-trar resulting in death) Last Due to (or as a consequence of) Physician/Medical that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy 1 Live Birth 2 Live Fetal death 23b. Was decedent pregnant 23d Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Pregnant at time of death Yes 2 No g Unknown Unknown ed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ρ 1 Yes 2 No 3 Probably 4 Unknown Completed Were autopsy findings available prior to completion of cause of death? 24a. Was an has autonsy page perform 1 Yes 2 No Yes To the Hospital or Attending Physician: 25. Was case referred to medical director, Be 26. Place of Death (Check only one) examiner? Yes Hospital 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) မ 1 Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at After t 28d. Describe how injury occurred 1 Natural work? 1 \(\text{Yes} \) 2 \(\text{No} \) 5 Pending iniury within 24 hours after death.

To the Funeral Director: As completed filled in by the fu Investigation Accident Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Homicide 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 29a. Certifier certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature 0018230 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

amend items 20a-c, 22 per fh g925 3-26-12 yt
State of Maryland / Department of Health and Mental Hygiene

		-	1 - State Registrar	Cei	rtificate of Deat			Reg. No. 2	112	08790
	Physicia	n/	Decedent's Name (First, Middle, Last)				2. Date of Dea Month	th Day	Year	3. Time of Death
and the	Medic	al	Walter John Goodman 4a. Facility Name (if not institution, give street and nun	abort	45 Oits Town and another	ion of Dogth	03		212	7:19 P M
\bigcirc	Examin	er	Union Memorial Hospit	•	4b. City, Town, or Locati			4c. County	or Death	
	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year If Un	der 24 Hrs.	8. Date of Birth	1	9. Birthp	lace (State or Foreign
10	Director		217-40-5657 1 XM 2 □ F Usual Residence of Decedent	69 Yrs.	Months Days Hou	rs Min.	Jan 9,	1943	Mai Mai	yland
	ryland -f show ed at	Director	10a. State 10b. County	10c. City, Town or Lo					1	0d. Inside City Limits
	e Ma r 28a notifi	Oire	MD 10e. Street and Number	Baltimo	re 10f. Zip Code			10g. Citizen of	14/1 -4 0	1 Yes 2 No
	with th	eral	1634 N. Broadway		21213			USA	what Cour	ury?
920	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	Completed by Funeral		2 ∐ No e	Was Decedent of Hispanic If Yes, specify Cuban, Mex 1 Yes 2 X No Spec		cify Yes or No- Rican, etc.)	Bla	ce - Americ ck, White, e , Blac	etc.
21215-0036	72 hour	mplete	15. Decedent's Education (Specify only highest grade completed,	(Give	dent's Usual Occupation kind of work done during r O NOT use retired)	most of workir	ng	16b. Kind of E	Business/Inc	dustry curity
212	withir giene er tha		Elementary/Secondary (0-12) College (1) adı	ministrative			Admi	nistr	ation
	be filed ental Hy ked oth ic event	To Be	17. Father's Name (First, Middle, Last) Walter John Goodman S	r.			(First, Middle, I Mae Goo		e)	
Maryland	2 should Ith and Me 27 is mar		19a. Informant's Name/Relationship (Type, Print) Gwendolyn Goodman – w	19b. Mailir	ng Address (Street and Nu. 34 N. Broadw	mber or Rural	Route Number, 1timore	City or Town, MD 21	State, Zip C	Code)
Baltimore,	Page 1 and nent of Hes ant: If item ary or othe		20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from 4 Donation 5 Other (Special In State	State	osition (Name of matory or other place)		7-12	20c. Location		wn, State
Balti	permit. Departri Importa any inju		21. Signatu a Ronal Service License Ronal Wash,		Name and Address of Fa	acility Ste ruggs intore	te Anat Fun eral St; Bal	Home 1 timore	412 F	Preston 21213
	Medical Examiner	Examiner	Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events c.	ch line. A cute rena (or as a consequence of): hole cystory or as a consequence of):	d failure tus opathy		, oop, acc, y are			Approximate Interval Between Onset and Death
. Box 68760	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/Medical E	d	come of pregnancy Birth 2 Fetal death 3 ann at time of death 5	Ectopic pregnancy Other (specify)				ate of delive	ery Day Year
s, P.O.	requires that the der been signed by the a should be detached	by	Part II. Other significant conditions contributing to c	eath but not resulting in the u	ınderlying cause given in F	Part I.				e cause of death?
Division of Vital Records,	sician: The law requ s certificate has beer lirector, page 2 shou	Completed					24a. Was a autop: perfor 1 Yes	med?	Were autop prior to con death? 1 \square Yes	osy findings available mpletion of cause of
a	ian: T ertifica ctor, p	Be C	25. Was case referred to medical examiner?		26. Place of	Death (Check		21200	1 🖂 100	
of Vii	y Physician: The law er this certificate has eral director, page 2	၉	1 Yes 2 No Hospital: 27. Manner of Death 28a. Date	npatient 2 ER/Outpatier of injury 28b. Time of	28c. Injury at		me 5 Reside			
on	Attending Ph sr death. ector: After th by the funeral	Certificate:	2 Accident Investigation	th, Day, Year) injury	work? M 1 ☐ Yes 2	2 🗆 No				
Divis	Hospital or Attending 24 hours after death. Funeral Director: After stely filled in by the fune		4 D Hamicide determined 28e. Place	of Injury - At home, farm, str ng, etc. (Specify)	eet, factory, office	2	28f. Location (St City or Town		er or Rural	Route Number,
	To the Hospital or A within 24 hours after To the Funeral Direct completely filled in by	Medical	29a. Certifier (Check (Check only one) (Check one) (Check only one) (Check one) (Check only one) (Check o	sis of examination and/or inves	tigation, in my opinion, deat	th occurred at	the time, date an	nd place, and du	e to the cal	use(s) and manner state
	To the within 2 To the comple	-	29b. Signature and title of certifier		29c. License numb			29d. Date signe		
			Lauren	MP	AT 24	3894	6	03/1	1/20	12
_/	3		30. Name and address of person who completed cause							
_			MANSOCK NG ZAYAN 31. Date filed, (Month, Day, Year)	egistrar's Signatura	salhmore 1	MD 2	1218			
	Sta [.] Registra		31. Date filed fiviority, Day, Year, 1.1.	egistrar s olgrania	2					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		_	rot	State of Maryland / Dep		d Mental Hygiene	e 2012 08791
			State Registrar	Ce	ertificate of Death	Reg. N	
	Physicia Medic		1. Decedent's Name (First, Middle, Last) GEOVGE HE	YVONNE G	riffith	March 1	year Year Sola 6.00 A M
	Examin	er	4a. Facility Name (if not institution, give street 15 30 North bo	urne Rol		nae	c. County of Death
	Funeral Director	- 1	5. Social Security Number 6. Sex 1 1 N	7. Age (In yrs. last birthday,	If Under 1 Year If Under 24 Months Days Hours I	Hrs. 8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
	d now	_	Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or L	ocation		10d. Inside City Limits
	Marylan 28a-f sh otified a	Director	ND NIF	P 11	inore		1
	with the 23a or 1st be n	Funeral D	10e. Street and Number	ourne Rol	10f. Zip Code 2/239	10g. C	Citizen of What Country?
9	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	by Fun		Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 NO	. Was Decedent of Hispanic Origin If Yes, specify Cuban, Mexican, F	? (Specify Yes or No- uerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
-003	nours aft natural", ical Exa	eted	3 Widowed 4 Divorced 15. Decedent's Education		1 Yes 2 Specify: edent's Usual Occupation	16b.	Specify: Black Kind of Business Industry
21215-0036	ithin 72 lene. r than "r the Med	Completed	(Specify only highest grade of Elementary/Seconday (0-12)	College (1-4 or 5+)	e kind of work done during most of DO NOT use retired) Q na dall Ma	nager D	ept of Social Service
and 2	uld be filed within Mental Hygiene. narked other tha natic event, the N	To Be	17 Father's Name (First, Middle, Last)	rd Bailey		Name (First, Middle, Maide)	n Sumame)
aryla	should be and Me is mark aumatic	7/2	19a. Informant's Name/Relationship (Type,	Print) 19b. Ma	iling Address (Street and Number of	or Rural Route Number, City o	or Town, State, Zip Code)
e, N	ge 1 and 2 sl nt of Health a if item 27 is or other tra		Tia Griff 17	arriS 153	position (Name of		Location - City or Town, State
altimore, Maryland	Page 1 ment of ant; If it ury or c		1 Naurial 2 ☐ Cremation 3 ☐ Re 4 ☐ Donation 5 ☐ Other (Specify)	noval from State Lorrou	ematory or other place)	3/23/2012 B	altimore, MD
Balt	permit. Page Department Important: I any injury o		21. Signatus of Funeral Service Lick nisee	Invel St.	22. Name and Address of Facility 333 i Brehm	Howell F S Ln, Bo	THIMORE, MD 21213
			23a. Part 1. Enter the disease, or complice shock, or heart failure. List only one of Immediate Cause (Final	ause on each line.			Approximate Interval Between Onset and Death
	Medical		disease or condition resulting in death)	Due to (or as a consequence of):	otic Capalion	rascular O	18056
1	Examiner	ner	Sequentially list conditions, if any, leading to immediate	Due to (or as a vonsequence of):	ension		
	ecuted and -transit	Examiner	cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last	Due to (or as a consequence of):			
09	requires that the death certificate be executed been signed by the attending physician and should be detached for use as the burial-transit	dical	d.				
(887)	certifica anding pl use as t	ın/Me	23b. Was decedent pregnant	. If yes, outcome of pregnancy 1 □ Live Birth 2 □ Fetal death 3	☐ Ectopic pregnancy		23d. Date of delivery
Box	ne death the atte	Physician/Me	in the past 12 months? 1 ☐ Yes 2 ☐ No g ☐ Unknown		Other (specify)		Month Day Year
, P.O.	The law requires that the death certifica rate has been signed by the attending pt page 2 should be detached for use as t	ρ	Part II. Other significant conditions control Breast cancer			()	o use contribute to the cause of death?
ords	w requir s been s should	Completed		, , , , , ,		24a. Was an autopsy	24b. Were autopsy findings available prior to completion of cause of
Rec	ician: The law certificate has rector, page 2 s		25. Was case referred to medical		26. Place of Death	performed?	? death?
Vita	ysiciar s certif directo	To Be	avaminar?	spital: 1 ☐ Inpatient 2 ☐ ER/Outpat	_ Other: _	sing Home 5 Residence	6 ☐ Other (Specify)
n of	ding Phy h. After thi funeral		27. Manner of Death 1 Natural 5 Pending 2 Accident Investigation	28a. Date of injury (Month, Day, Year) 28b. Time injury	of 28c. Injury at	28d. Describe how inj	jury occurred
Division of Vital Records,	or Atten after deal Director: in by the	Certificate:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At home, farm, building, etc. (Specify)	street, factory, office	28f. Location (Street a City or Town, Sta	and Number or Rural Route Number, ate)
Ω	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completed filled in by the funeral director,	Medical	(Check 2 Medical Examine)	an: To the best of my knowledge, deal : On the basis of examination and/or inv	restigation, in my opinion, death occi	urred at the time, date and pla	ace, and due to the cause(s) and manner stated.
	To the I within 2 To the I comple	Me	only one) 3 Certifying Nurse I 29b. Signature and title of certifier	ractioner: To the best of my knowledg	29c. License number		pate signed (Month, Day, Year)
			30. Name and address of person who com	pleted cause of death (Item 23a) (Type	D D690	97	5/20/2012
			Letita J.	VRight, M	D. 1000 E	Eager 8	4. Balto. 2120
	Sta Registr		31. Date filed (Month, Day, Year) NAR 2.1 2012	32. Registrar's Signature	de		,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 12:12 Am Mon3/19/2012 Physician/ Malone Gouge 4c. County of Death Medical 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) Carroll Examiner Westminster Carroll Hospital Center 9. Birthplace (State or Foreign Country) NC 8. Date of Birth If Under 1 Year If Under 24 Hrs 7. Age (In yrs. last birthday) 972971926 Social Security Number Hours Funeral 1 XM 2 □ F 85 404-42-8732 Director 10d. Inside City Limits Usual Residence of Decedent 10c. City, Town or Location Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or items 23a or 28a-f show ury or other traumatic event, the Medical Examiner must be notified at ury or other traumatic event, 10a. State 10b. County 1 Tyes 2XXNo Director Mt. Airy Frederick 10g. Citizen of What Country? MD 10f. Zip Code 10e. Street and Number USA 21771 Funeral 4500 Buffalo Rd. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Black, White, etc. 11. Marital Status Armed Forces? Yes 1 Never Married 2 X Married White þ 1 Yes 2XX No Specify: If Yes, Give Year or Dates Baltimore, Maryland 21215-0036 3 Widowed 4 Divorced Completed 16b. Kind of Business Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education (Specify only highest grade completed) M. Gouge & Son College (1-4 or 5+) Elementary/Seconday (0-12) Saw_Mill Owner/Operator 6 18. Mother's Name (First, Middle, Maiden Surname) Be 17. Father's Name (First, Middle, Last) Eva McKinney ပ္ Arnold Gouge 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 3225 W. Old Liberty Rd., New Windsor, MD 21776 Kathleen Burleson/Daughter 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Sykesville, MD 1 X Burial 2 Cremation 3 Removal from State 3/22/2012 Department of I Important: If it any injury or o Lake_View_Mem. Park 4 Donation 5 Other (Specify) 22 Name and Address of Facility Funeral Home & Crematory, P.A. Signature of Funeral Service Licensee 1212 W. Old Liberty Rd., Winfield, MD Torbit Cellio 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death FIBRILLATION 1 vetaus Immediate Cause (Final disease or condition Physician/ resulting in death) Medical ENCEPHALO PATHY Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of) Examine sate has been signed by the attending physician and page 2 should be detached for use as the burial-transit requires that the death certificate be executed Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 23d. Date of delivery 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death IF FEMALE: 23b. Was decedent pregnant 3 Ectopic pregnancy 5 Other (specify) Month Live Birth 2 Live Birth 2 Pregnant at time of death in the past 12 months? 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 3 Probably 4 Unknown ATRIAL FIBRILLATION 1 Yes þ 24b. Were autopsy findings available prior to completion of cause of death? ovonary Hear discare Completed 24a. Was an autopsy 2 No 1 Yes Yes 26. Place of Death (Check only one, 25. Was case referred to medical examiner? 1 Yes 2 No eral Director: After this certific filled in by the funeral director, Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA ၉ 28d. Describe how injury occurred 28c. Injury at work? 28a. Date of injury (Month, Day, Year) 28b. Time of 27. Manner of Death Certificate: 1 Yes 2 No 5 Pending Natural 28f. Location (Street and Number or Rural Route Number, City or Town, State) Investigation ☐ Accident ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 6 Could not be 4 Homicide determined Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 24 hours a To the Funeral C 29a. Certifier (Check only one) 29d. Date signed (Month, Day, Year) and title of certific D0018200 30. Name and address of person who completed cause of Death (Item 23a) (Type, Print) 700 A PW & Rd, WESTMINSTER 2115

State Registrar Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Philip Joseph Gilberti 2012 08793 1- For State Certificate of Death Reg. No Registrar 1. Decedent's Name (First, Middle,Last) Physician/ 2. Date of Death Month Medical Examiner Philip Joseph Gilberti 2240 hrs March 13, 2012 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 823 Fordham Road Rockville Montgomery 5. Social Security Number 7. Age (In yrs, last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or **Funeral** Months Oays Hours oreign Director UNK 1X M 2 F 51 Country) Yrs 05/05/1960 WashDC Usual Residence of Decedent 10a. State 10c. City, Town or Location iny 10b. County 10d. Inside City Limits MD 28a-f sho₩ Rockville 1 Yes 2 X No Montgomery ies 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 10401 Grosvenor Place Unit 1226 20852 USA 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, Armed Forces If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. 1 Never Married 2 Married Yes 5 White 4 Divorced If Yes, Give Year or Dates: 1 Yes 2 No specify: <u>۾</u> 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) timore, MD 21215-0036 Driver Trucking 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Joseph Gilberti Gloria Reyes 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Gloria Holcomb Mother 3601 Lawrence Ave Kensington MD 20895 If item 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State Pages 1 ment of 7 1 Burial 2 X Cremation 3 Removal from State crematory or other place) Atlantic Crem 03/16/12 Glen Burnie MD Donation 5 Other Specify 22. Name and Address of Facility Simplicity Crem & Fun Serv 21 Signature of Funeral Service Licens ThomasAllenPA 7090 Ridge Rd Hanover MD 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval **Physician** failure. List only one cause on each line Between Onset and **rMedical** Death a intraoral Gunshot Wound Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions. if any, leading to immediate Due to (or as a consequence of) Examine cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and Physician/Medical UNPENDED g physician s the burial -AMENDED Division of Vital Records, P.O. Box 68760, IF FEMALE: 23c. If yes, outcome of pregnancy 23d, Date of delivery attending por use as the 23b. Was decedent pregnant in the 2 Fetal death Live birth 3 Ectopic pregnancy Year past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown 9 Unknown signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ 1 Yes 2 ✓ No 3 Probably 4 Unknown Completed certificate has been ector, page 2 should 24a, Was an 24b. Were autopsy findings available autopsy prior to completion of cause of death? performed? page Yes 2 No 1 🗸 Yes 25. Was case referred to medical 26.Place of Death (Check only one) To the Hospital or Attending Physician: Be Hospital: 1 Inpatient After this c funeral dire Other₄ 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 Other: Scene 1 Yes 28a. Date of Injury FOUND: 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification Subject shot self Natural FOUND: 5 Pending 1 Yes 2 ✔ No Director: after death. Mar 13, 2012 2240 hrs 2 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City 3 V Suicide Could not be or Town, State) 823 Fordham Road, Rockville, MD determined (Specify) Single Family Home Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) one) and manner stated. Signature and title of certifier 29b. 29c. License number 29d. Date signed (Month. Day Year) O.C.M.E. March 14, 2012 3M 30. Name and address of person who completed cause of death (Item 23a) Patricia Aronica-Pollak MD. Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

DHMH 17 Rev 1/2001 OCME 2006

OCME

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death $\underline{20}^{\text{Day}}$ Month March Physician/ 2012 Year 10:00 a M Doraldina L. Guthrie Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Howard Columbia Gilchrist Hospice Care 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Social Security Number **Funeral** (Month, Day, Year) Months Hours Country **Director** 218-01-5143 90 MD 08/22/1921 Usual Residence of Deced show 10d. Inside City Limits 10a. State 10b. County 10c. City. Town or Location notified at **Funeral Director** 28a-f Ellicott City 1 Yes 2 X No MD Howard 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? ō items 23a or ner must be n 21042 3824 Palmetto Court United States death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status ian "natural", or itel Medical Examiner Armed Forces?
1 ☐ Yes 2 X No þ 1 Never Married 2 Married Page 1 and 2 should be filed within 72 hours after ment of Health and Mental Hygiene. Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: If Yes, Give Year or Dates Specify: White 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry alth and Mental Hygiene.

127 is marked other than is traumatic event, the Me Elementary/Secondary (0-12) College (1-4 or 5+) Tailor Men's Clothing 8 Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) မ Margherita DiGirolamo Giuseppe Valenti 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3824 Palmetto Court Ellicott City, MD 21042 Roy Guthrie - Husband Department of Health Important: If item 27 any injury or other to once. 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of Date cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 X Other (SpecifyIntombment Lorraine Park Cem. 03/23/2012 Baltimore, MD Signature of Funeral Service Licensee 22. Name and Address of Facility Harry H. Witzke's Family FH Inc. Them Colla 4112 Old Columbia Pike Ellicott City, MD 21043 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Athero Sclerotic VTANOTO eavs disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, Examine Due to (or as a consequence of) if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events To the Hospital or Attending Physician; The law requires that the death certificate be executed the burial-transi Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No ☐ Live Birth 2 ☐ Fetal death
☐ Pregnant at time of death Month Day 5 Other (specify) signed by the at d be detached for 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Diabetes Mellitus Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No Chronic kidney 24a. Was an disease autopsy performed To Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 2 M No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify funeral 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28b. Time of Certificate: 28d. Describe how injury occurred 1 Natural injury 5 Pending Investigation Could not be within 24 hours after death

To the Funeral Director: A
completely filled in by the f Accident Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check

State

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

6336

Registrar DHMH 17 Rev 06-2011 29c. License number

00060634

ANG, COLUMBIA

29d. Date signed (Month, Day, Year)

3/20/12

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 12:15 PM ari Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Centerrille 7. Age (In yrs. last birthday) 87 Yrs. 8. Date of Birth If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) Sex 1 M 2 F **Funeral** (Month, Day, Director Usual Residence of Decedent items 23a or 28a-f show 10a. State 10b. Count 10c. City, Town or Location 10d. Inside City Limits within 72 hours after death with the Maryland other traumatic event, the Medical Examiner must be notified at Director 1 No Yes 2 No 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 21638 Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces? Black, White, etc. 1 Never Married 2 Married ō Completed by 3altimore, Maryland 21215-0036 1 Yes 2 No Specify Specify: WKI te If Yes, Give "natural", 3 ₩Widowed 4 □ Divorced Year or Dates. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry al Hygiene. I other than " Elementary/Seconday (0-12) College (1-4 or 5+) Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental Fishers is marked o ဂ္ permit. Page 1 and 2 should be Department of Health and Ment Important: If item 27 is marke any injury or other traumatic once. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) MOND 20a. Method of Disposition 20b. Place of Disposition (Name of Date ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State cemetery, crematory or other place) 4 Donation 5 Other (Specify) Signature of Eur 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) CORONARY Medical Examiner HYPERTER Sequentially list conditions, Examiner it any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to for as a currequence of: To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. by the attending physician and stached for use as the burial-transit that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?

1 Yes 2 No Month Pregnant at time of death been signed by the s should be detached g Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown Were autopsy findings available prior to completion of cause of death? 24a. Was an within 24 hours after death.

To the Funeral Director: After this certificate has completed filled in by the funeral director, page 2 seconcepts. performed? 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital 2 No Certificate: To 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred (Month, Day, Year) 1 Natural injury 5 Pending 2 Accident Investigation Suicide 6 Could not be 3 ☐ Suicide 4 ☐ Homicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Dertifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier K163758 -12

State

DHMH 17 Rev 7/2009

Registrar

Shivene

31. Date filed (Month, Day, Year)

trostrava

AUE

CENTERVILLE MD

205

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

mett crop

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene = State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ 7:35 2012 Ardna Gallion March 18 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Harford Havre de Grace Harford Memorial Hospital If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Social Security Number 6. Sex 7. Age (In vrs. last birthday) **Funeral** Days (Month, Day, Yo 4/8/1942 USA Country) Hours Min. 1 □ M 2 🛱 F 69 Yrs. Director 220-40-9142 Usual Residence of Decedent 10d. Inside City Limits 10h County 10c. City, Town or Location should be filed within 72 hours after death with the Maryland Director ms 23a or 28a-f s must be notified 1 Yes 2 No <u>Harford</u> Aberdeen Maryland 10g. Citizen of What Country? 10e. Street and Number 10f, Zip Code 21001 Funeral 3749 Aldino Road Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2X No "natural", or iter Black, White, etc. 1 Never Married 2 Married þ Specify: White Maryland 21215-0036 1 Yes 2 No Specify: If Yes, Give Year or Dates Completed 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Me College (1-4 or 5+) Elementary/Seconday (0-12) At Home Homemaker 0 10 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Annie Grogan Charles Toliver 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3749 Aldino Rd, Aberdeen, MD 21001 Earl Gallion / Husband Baltimore, 20a, Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 XBurial 2 Cremation 3 Removal from State 3/21/2012 Havre de Grace, MD Rock Run Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of June 22. Name and Address of Facility Tarring-Cargo Funeral Home, P.A. 333 S. Parke St. Aberdeen, MD 21001 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Priysician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, Due to (or as a consequence of) if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events Exami To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and attending physician and for use as the burial-tran Due to (or as a consequence of) resulting in death) Last Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 23d Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ Live Birth 2 - Fetal death in the past 12 months? Pregnant at time of death Yes 2 No 9 Unknown been signed by the should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Records, Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed Yes 2 No Yes filled in by the funeral director, 25. Was case referred to medica 26. Place of Death (Check only one) Division of Vital Be examiner? Other: 1 Inpatient R ER/Outpatient 3 IDOA 2 No 4 Nursing Home 5 Residence 6 Other (Specify) Certificate: To 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural (Month, Day, Year) 5 Pending 1 Yes 2 No Investigation Accident 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completed 3 🗆 only one) 29b. Signature and title of 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 1 - For State Registra Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 02:00 AM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4. County of Death **Examiner** SUDBROOK LANE BALTIMORE BALTIMORE 7. Age (In yrs. last birthday) If Under Year If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) Social Security Number **Funeral** Min Hours (Month, Day, Year) 220-14-0636 Director 1 □ M 2 🗓 F 88 08/28/1923 MD or 28a-f show notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 🗆 Yes 2 😾 No MD BALTIMORE BALTIMORE 0 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? must be n Funeral 7 SUDBROOK LANE 21208 USA within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes, Give Year or Dates. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Examiner Black, White, etc. ò 1 X Never Married 2 Married þ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify Specify "natural" 3 Widowed 4 Divorced Completed WHITE Medical 16a. Decedent's Usual Occupation Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) filed within 72 tal Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) the FACTORY WORKER UPHOLSTERY Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental I ဂ္ Page 1 and 2 should be HYMAN **GARBUS** GOLDIE SACHS 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) BEVERLY VENICK/SISTER 7311 PARK HEIGHTS AVENUE, #302, BALTIMORE, MD 21208 20a. Method of Disposition 20b. Place of Disposition (Name of permit. Page 1
Department of
Important: If if
any injury or o MTKROCKODESHEBE ISRAEL CEMETERY 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 03/18/2012 BALTIMORE, MD SOL LEVINSON & BROS., INC. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 21208 23a. Part 1. Enter the disease, or complications shock, or heart failure. List only one cause Immediate Cause (Final disease or condition resulting in death) sease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Onset and Death Physician/ Medical as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) -transit that initiated events resulting in death) Last and Due to (or as a consequence of): attending physician a Physician/Medical certificate be Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) Live Birth 2 Fetal death in the past 12 months? Month Pregnant at time of death Day Year 1 Yes 2 No be detached the P.O. been signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Hospital or Attending Physician: The law requires Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed plnous 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy perform 2 No 1 Yes Yes 2 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: 2 X No Other: P Nursing Home 5 Residence 6 Dother (Specify) 1 Inpatient 2 I ER/Outpatient 3 DOA filled in by the funeral 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 24 hours after death. Funeral Director: After 1 Natural 5 Pending 1 Tes 2 No ☐ Accident ☐ Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, Homicide determined City or Town, State) Medical 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated within 2 To the I only one) 29b. Signature a se of death (Item 23a) (Type, Print)

Registrar

DHMH 17 Rev 06-2011

State

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. for State Registrar State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Year AM 1030 Nara Medical a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Memoria 8. Date of Birth (Month, Day, If Unde Birthplace (State or Foreign Country) **Funeral** Age (In vrs. last birthday) If Under 24 Hrs. Hours Min Director 1 □ M 2 🗹 F 0 show 10a. State 10b. County 10c. City, Town or Location nside City Limits must be notified at Director 28a-f 1 es 2 No mor 5 10e. Street and Number 10g. Citizen of What Country? Funeral 23a items 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. the Medical Examiner Black, White, etc. ō þ 1 Never Married 2 Married 1 Yes Saltimore, Maryland 21215-0036 1 Yes 2 No Specify. 3 Widowed 4 Divorced "natural" Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) nd Mental Hygiene. marked other than Elementary (Secondary (0-12) College (1-4 or 5+) Johns Hopkins traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) n and Mental I ပ permit. Page 1 and 2 should be 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Important: If it any injury or o once. 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Juheral Service Licens WSS. tuneral/Home, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death Ph_sician/ Erdiac disease or condition resulting in death) my thonia 0 minuts Medical Due to (or as a consequence of) Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): that initiated events resulting in death) Last Due to (or as a consequence of): signed by the attending physician Physician/Medical P.O. Box 68760 the k as t IF FEMALE: for use 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 Fetal death 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Day Pregnant at time of death Month Year No Unknown Unknow Hospital or Attending Physician; The law requires that the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 19 rge cell tymphoma of Records, 3 Probably 4 Unknown No Completed peen 24b. Were autopsy findings available prior to completion of cause of 24a. Was an page 2 certificate has autopsy perform death? Yes 2 1 Yes Division of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 🗌 Yes 2 No Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) this 27 Map er of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director, After Natural 5 Pending 1 🗌 Yes 2 🗌 No Accident the Investigation 6 Could not be Suicide 3 ☐ Suiciae 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined Medical certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier 3 🗆 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29c. License number MD DOO6496. 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BALTIMORE MARYLAN

Registrar DHMH 17 Rev 06-2011

State

Meghan Checkle

31. Date filed (Month, Day, Year)

EAST UNIVERSITY

PARKMA

201

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible,

State of Maryland / Department of Health and Mental Hygiene For
State
Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Marie Hill-Phillips Uneeda 4:13 A M 2012 March Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Southern Maryland Hospital Clinton Prince George's 5. Social Security Number If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days 578-94-3773 39 Director 1 🗆 M 2 🗶 F October 3 1972 Washington, DC 28a-f show notified at 10a State 10b. County 10c. City. Town or Location 10d. Inside City Limits Director MD Prince George's Capitol Heights 1 Yes 2 No 10e. Street and Number ò 10f. Zip Code 10g. Citizen of What Country? er than "natural", or items 23a or the Medical Examiner must be Funeral 20743 6004 Apple Grath USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 Yes 2 No Black, White, etc. 1 Never Married 2 Married þ Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify. Specify: Black 3 Widowed 4 Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) should be filed within 72 and Mental Hygiene.
7 is marked other than "r Elementary/Secondary (0-12) College (1-4 or 5+) Private 12th Nursing Assistant other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ permit. Page 1 and 2 should be Department of Health and Ment. Important: If item 27 is marked any injury or out. Roland Hill Jacqueline Mills 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Roland Τ. 1914 County Road, Forestville, Maryland 20747 Moss Jr. Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 03/21/2012 Landover, Maryland Harmony Cemetery 22. Name and Address of Facility J.B. Jenkins Funeral Home 21. Signature of Funeral Service Licensee 7474 Landover Road, Landover, Maryland 20785 23a. Part 1. Errier the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death BILATERAL Immediate Cause (Final DULMONARY Ph sician/ EMBOLI disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, If any, leading to immediate cause. Enter Underlying Due to (or as a consequence of, Examin Cause (Disease or injury that initiated events burial-trar Due to (or as a consequence of) resulting in death) Last physician s the burial Physician/Medical that the death certificate be P.O. Box 68760 ding IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Year Pregnant at time of death Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ MORBUD OBESIT Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed HYPERTENSION 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autops 1 Ses 2 No 2 No or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No ပ္ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Watural 5 Pending injury work? 1 ☐ Yes 2 ☐ No within 24 hours after death. To the Funeral Director: A Accident Investigation 3

Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) To the Hospital Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier completely (Check 3 🗆 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) rrott State

DHMH 17 Rev 06-2011

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Month Year Carl Ε. Hollins 7:34 AM March 2012 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Washington Adventist Hospital Takoma Park Montgomery If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth Birthplace (State or Foreign Country) Hours (Month, Day, Year) 578-82-4858 1**X** M 2 □ F 43 June 24 1968 Washington, DC 10a. State 10c. City. Town or Location 10d, Inside City Limits Washington DC 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1727 Capitol Avenue, NE, Apt #1 20002 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 11. Marital Status 14. Race - American Indian, Armed Forces? 1 Yes 2 No Black, White, etc. 1 X Never Married 2 Married 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates Specify: Black 3 Divorced 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working 16b. Kind of Business/Industry life, DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Private Driver 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Carl E. Hollins Sally Eady 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2000219a. Informant's Name/Relationship (Type, Print) Sally Eady/ Mother 1727 Capitol Avenue, NE, Apt#1, Washington, DC 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State 03/20/2012 Suitland, Maryland 4 Donation 5 Other (Specify) Lincoln Cemetery 21. Signature of Funeral Service Licensee 22. Name and Address of Facility J.B. Jenkins Funeral Home 7474 Landover Road, Landover, Maryland 20785 23a. Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. Ust only one cause on each line. Interval Between Immediate Cause (Final disease or collition resulting in death) Onset and Death Due to (or as a consequence of 0 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) yes, outcome of pregnancy Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? 1 ☐ Yes 2 ☐ No Pregnant at time of death Month Day Year Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🔀 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed?

Physician/ Medical Examiner

Physician/

Medical

Director

by Funeral

Completed

Be

೭

Examiner

Funeral

Director

28a-f show

9

23a

items ;

ō

"natural",

Page 1 and 2 should be filed within 72 hours after death

id Mental Hygiene. marked other than

f Health item 27

Lepartment of H Important: If iten any injury or car

other traumatic

Baltimore, Maryland 21215-0036

event, the Medical Examiner must be notified at

use as the burial-transi attending physician P.O. Box 68760 signed by the a d be detached f Division of Vital Records, page 2 certificate has the Hospital or Attending Physician: hin 24 hours after death. the Funeral Director: After this certific

Examine Physician/Medical ģ Completed Be ပ Certificate:

Medical

funeral director, filled in by the

completely within 2. Q

Registrar

Yes 2 No Yes 2 140 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Yes 2 No 1 Npatient 2 -ER/Outpatient 3 DQA 28a. Date of injury (Month, Day, Year) 27. Manne f Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 \square Pending Natural work? 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined

29a, Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 60100 00

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BUD East University

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ F. Ernest Horn Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Doctors Community Hospital Lanham Prince George's If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. Social Security Number Age (In vrs. last birthday 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Months 579-56-7119 1**X** M 2 □ F **Director** 68 Yrs. Sept 15 1943 Washington, DC show 10a. State 10c. City, Town or Location 10d. Inside City Limits notified at Director MD Prince George's Lanham 28a-f 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 9 10g. Citizen of What Country? must be r Funeral 10312 Garson Terrace 20706 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian. r than "natural", or iter the Medical Examiner Armed Forces? Black, White, etc. 1 Never Married 2 X Married þ Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: If Yes, Give Year or Dates. Army Specify: Black 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working al Hygiene. life. DO NOT use retired) College (1-4 or 5+) Government Adjudcator injury or other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental F ဂ္ Grace L. Saunders Ernest D. Horn 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) / Wife Department of Health a Important: If item 27 Emma Horn 10312 Garson Terrace, Lanham, Maryland 20706 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 ☐ Burial 2 🖟 Cremation 3 ☐ Removal from State 03/22/2012 Riverdale, Maryland Riverdale Crematory ☐ Donation 5 ☐ Other (Specify) 21. Signature of Feneral Service Licensee 22. Name and Address of Facility J.B. Jenkins Funeral Home 7474 Landover Road, Landover, Maryland 20785 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Examiner MONIN Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) burial-trar that initiated events resulting in death) Last Due to (or as a consequence of): physician s the burial Physician/Medical P.O. Box 68760 attending ph IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 Fetal death 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Day Year Pregnant at time of death been signed by the a should be detached 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 1 Yes 2 No 3 Probably 4 Y Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Hospital or Attending Physician: The law within 24 hours after death.

To the Funeral Director, After this certificate has completely filled in by the funeral director, page 2 autopsy performed 2 🗆 No 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital: Other: ည 1 🗌 Yes 2 No 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred (Month, Day, Year) 5 Pending **Natural** 2 Accident
3 Suicide
4 Homicide 1 Yes 2 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 29a. Certifier 🔛 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Registrar
DHMH 17 Rev 06-2011

8

State

EUG ENE

son who completed cause of death (Item 23a) (Type, Print)

M.D.

CRA16

MDD 41608

8909 OLD BRANCH AVENECLINTOR,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death Time of Death Physician/ Manth 3:43 PM 1-1911 2017 Medical 4a. Facility Name (if not institution, give street and number) or Location of Death Examiner 4c. County of Death Himore Secour a If Under 1 Year If Under 24 Hrs. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Min. Hours 1 M 2 XF 08-04-40 Country) 169-34-7966 **Director** 71 NC Usual Residence of Decedent shov Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or items 23a or 28a-f show nartment of Health and Mental Hygiene. ortant: yor items 23a or 28a-f sho ortant: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 No Baltimore NA MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Completed by Funeral 3600 W. Franklin Street reet Apt #1
Was Decedent Ever in U.S Was Decedent of Hispanic Origin? (Specify Yes or No-11. Marital Status 14. Bace - American Indian Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. African 1 Never Married 2 Married Yes 2 X No Baltimore, Maryland 21215-0036 1 Yes 2 X No Specify. If Yes. Give Specify: American 3 Widowed 4 □ Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Housekeeper Domestic 12th Grade Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Barber Katie John Hall 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2559 W. Lombard Street Baltimore, Maryland 21223 Jacqueline Johnson-Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1 a
Department of H
Important: If ite
any injury or ot Date cemetery, crematory or other place) 1 K Burial 2 Cremation 3 Removal from State 03-23-12 Loudon Park Cem. Baltimore, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signatule of Funeral Service Licenses 22. Name and Address of Facility 22. Name and Address of Facility Wylie Funeral Home P.A. 638 N. Gilmor Street Baltimore, Maryland 21217 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between 5 Onset and Death Immediate Cause (Final Physician/ respirator disease or condition Medical resulting in death) Examiner hronic Obstructive Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Physician/Medical Examiner Cause (Disease or iinjury that initiated events resulting in death) Last be detached for use as the burial-transi attending physician and Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Day Pregnant at time of death Unknown ☐ Yes 2 ☐ Unknow No Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown completed filled in by the funeral director, page 2 should Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perfor 2 No 1 Yes Yes To the Hospital or Attending Physician: 25. Was case referred to medica Be 26. Place of Death (Check only one) examiner? 2 No Other: 1 Yes 1 Nnpatient 2 ER/Outpatient 3 DOA P 4 Nursing Home 5 Residence 6 Other (Specify) 27 Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 5 Pending Natural 1 Yes Accident Suicide Investigation Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number Homicide City or Town, State) within 24 hours a To the Funeral C Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and tit 29c License number 29d. Date signed (Month, Day, Year) D6626 Mar

Registrar
DHMH 17 Rev 7/2009

State

Date filed (Month, Day,

ne and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last, 2. Date of Death Month Day **Physician** nerino MANCH Hand /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number, 4b. City, Town, or Location of Death Examiner Social Security Number 6. Sex 7. Age (In vis 8. Date of Birth (Month, Day, Ye 1–21–1934 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** Months Days Hours Min. 1 □ M 2 🛱 F 213-30-2945 78 Director MD Usual Residence of Decedent the Maryland 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 28a-f show 7 is marked other than "natural", or items 23a or 28a-f shov traumatic event, II a Nedical Evanther i ust be mittled at n/a Baltimore 1XYes 2 □ No Director MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Pages 1 and 2 should be filed within 72 hours after death with 2804 Hillsdale Road 21207 USA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 █ No 14 Race - American Indian 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 □ Yes 2 □XNo Specify African-American ş 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) tal Hygiene. Elementary/Secondary (0-12) 12th College (1-4or 5+) Clerk Social Security 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be is marked ot James Draper Sr Hattie Ferguson ဂ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s Department of Health ar Important: If item 27 is any injury or other trau Marcia W. Handy-Johnson/Daughter 2804 Hillsdale Road, Baltimore, MD 21207 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Furial 2 ☐ Cremation 3 ☐ Removal from State Maryland National Cemetery 3-22-2012 Laurel, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Sign were of Functal Service Algense 22. Name and Address of Facility Wile Fun-al Home P.A. of Balto. Co. 9200 Liberty Road, Randallstown, Md 21133 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one gause on each line. Immediate Cause (Final **Physician** SEEDIS disease or condition resulting in death) /Medical Due to (or a a consequence of): Examiner Due Flor as a consequence of Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Hospital or Attending Physician: The law requires that the death certificate be executed and burial-tran Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d Date of delivery 23b. Was decedent pregnant 3 D Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🕱 No Month Day Year 5 Other (specify) cate has been signed by the page 2 should be detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I ş 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? 1 Yes 2 No director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 X No 1 💢 Inpatient 2 ER/Outpatient 3 DOA Certification: To this funeral 28b. Time of Injury 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred After 5 ☐ Pending investigation 1 🔀 Natural death. 1 ☐ Yes 2 ☐ No 2 Accident after death Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Description of the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical completely (Check only one) and manner stated within 2 the 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) Morch 15, 2012 DD000 mppo 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

ď

State Registrar rac/

31. Date filed (Month, Day, Year)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician/ NES 0 20/2 C 10 Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town or Location of Death 4c. County of Death Examiner Baltimore S Monos 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, 9. Birthplace (State or Foreign **Funeral** Country)unk Director 229 352 1 M 2 D F 86 Yrs 28a-f show 10a. State 10b. County 10d. Inside City Limits notified at 10c. City, Town or Location Director MD Baltimore 10e, Street and Number 10f. Zip Code ō 10g. Citizen of What Country? er than "natural", or items 23a or the Medical Examiner must be Funeral 21211 USA 2095 Rock Rose Ave. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status unk 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces? unk Black, White, etc. þ 1 Never Married 2 Married Maryland 21215-0036 white If Yes, Give Year or Dates 1 ☐ Yes 2 XNo Specify: 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation unk 16b. Kind of Business/Industry (Give kind of work done during most of working Il Hygiene. life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) should be filed within and Mental Hygien unk unk Be unk 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 traumatic 1 and 2 should but Health and Meitem 27 is mark 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Baltimore City Commission on Aging 201 E. Baltimore St. Baltimore, MB Arti Shaw - guardian injury or other Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1 a Department of H Important: If ite any injury or ot cemetery, crematory or other place) ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Signature Funeral Sovice Lic RONAL S 22. Name and Address of Facility State Anatomy Board Director Baltimore St; Baltimore, MD 21201 655 W. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Sause (Final Physician/ disease or condition Medical resulting in death) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine that the death certificate be executed Cause (Disease or injury that initiated events attending physician and for use as the burial-tran Due to (or as a consequence of) resulting in death) Last Physician/Medical 68760 IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery Box (3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months? Month Pregnant at time of death Unknown 2 No g Unknown P.O. signed by t d be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 D Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has page 2 s autopsy perforn death? Yes Vital 25. Was case referred to medica Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes P 1 Inpatient 2 ER/Outpatient 3 DOA of funeral 28a. Date of injury (Month, Day, Year) 28c. Injury at Manner of Death 28b. Time of Certificate: 28d. Describe how injury occurred To the Hospital or Attending Natural 5 Pending within 24 hours are to To the Funeral Director: After manuletely filled in by the fur Division 1 Yes 2 No 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide Accident Investigation Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3. Time of Death

925PM

1X Yes 2 ☐ No

Interval Between

Onset and Death

Year

29d. Date signed (Month, Day, Year)

State Registrar

Eutew St. Ba 31. Date filed (Month. Day, Year 2012 MAR 21

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

and title of certifie

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death TR. Month Day **Physician** PM JAMES HI LDEBRAND MARCH 2012 16 /Medical 4a. Facility Name (If not institution, give street and number 4b. City, Town, or Location of Death 4c. County of Death Examiner N/A Johns Hopkins Bayview Medical Center **Baltimore** 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) **Funeral** 1X M 2 . F Months Days Hours Maryland Director 220-36-9524 71 Jan. 15,1941 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b County show Dunda1k 1 Tes 2 No Director notified MD Baltimore 28a-f the 10e. Street and Number 10f. Zip-Code 10g. Citizen of What Country? 23a or Pages 1 and 2 should be filed within 72 hours after death with must be 18 Broadship Road 21222 United States Funeral items 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Race - American Indian. ral", or item Black, White, etc 1 Never Married 2 Married 1 Yes If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify þ White 3 Widowed 4 Divorced Year or Dates 'natural", Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education Medical (Specify only highest grade completed) Home al Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) Contractors the Painter 3 Years Ith and Mental Hygie 27 is marked other r traumatic event, th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be James A. Hildebrand, Sr. Mary E. Cropsey ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8215 Bambridge Ct. 21122 Pasadena, Maryland Kathy Deickman (Daughter) Health a Department of Healt Important: If item 2 any injury or other once. 20a Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial Cremation 3 Removal from State Hilltop Service Corp. 3/21/2012 Towson, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Ave. Dundalk, Maryland 21222 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Sepsis disease or condition resulting in death) /Medical as a consequence of) Due to (or **Examiner** Pneumonia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) cause (Disease or Injury that initiated events resulting in death) Last certificate be executed physician and as the burial-trans Due to (or as a consequence of): of Vital Records, P.O. Box 68760, Physician/Medical as attending IF FEMALE use 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? for Month Year Dav 4 Pregnant at time of death 5 Other (specify) 2 No the 9 Unknown 9 Unknown The law requires that the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 onknown 1 Yes Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy certificate has performed? 2 H 2 🗆 No 25. Was case referred to medical examiner? filled in by the funeral director, 26. Place of Death (Check only one) Be 1 ☐ Yes 2 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA မ this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 1 Matural 28b. Time of Injury at Work? 28d. Describe how injury occurred Certification: s after death. Division 5 Pending investigation Injury 1 🗌 Yes 2 No 2 Accident Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide or A To the Hospital within 24 hours a To the Funeral D Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) completely and manner stated.

State Registrar

3

31. Date filed (Month, Day, Year)

ARVIND

30. Name and address of person who completed cause

K- PANDEY

29b. Signature and title of certifie

death (Item 23a) (Type, Print)

29c. License number

RES-000

29d. Date signed (Month, Day, Year)

March 16,2012

4940 Eastern Avenue, Baltimore, MD, 21224

			1 _ State	oartment of Health and Nertificate of Death		2012 0880
	Physicia	ın/	1. Decedent's Name (First, Middle, Last) Ella Mae Helmick			Day Year 3. Time of Death
	Medic Examir		4a. Facility Name (if not institution, give street and number) 2433 Harkins Road	4b. City, Town, or Location of Death White Hall		19 2012 12:35 A M 4c. County of Death Harford Co.
	Funeral Director		5. Social Security Number 6. Sex 1 M 2 🛱 F 7. Age (In yrs. last birthday) 1 M 2 🛱 F 82 Yrs. Usual Residence of Decedent	Months Days Hours Min.	8. Date of Birth (Month, Day, Yea Dec 26,	9. Birthplace (State or Foreign Country) 1929 Virginia
	Maryland 28a-f show otified at	irector	10a. State 10b. County 10c. City, Town or I MD Harford	ocation White Ha	.11	10d. Inside City Limits 1 □ Yes 2 🖾 No
	s 23a or sust be n	eral D	10e. Street and Number 2433 Harkins Road	10f. Zip Code 21161		Citizen of What Country?
9600	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	Be Completed by Funeral Director	11. Marital Status 1 □ Never Married 2 □ Married 3 ☒ Widowed 4 □ Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Yes 2 ☒ No If Yes, Give Year or Dates.	. Was Decedent of Hispanic Origin? (Spe If Yes, specify Cuban, Mexican, Puerto 1 ☐ Yes 2 ☑ No Specify:	ecify Yes or No- Rican, etc.)	14. Race - American Indian, Black, White, etc. Specify: White
Maryland 21215-0036	within 72 hor giene. ner than "nat t, the Medica	S Comple	(Specify only highest grade completed) (Giv	edent's Usual Occupation e kind of work done during most of work DO NOT use retired) Nurse	ing 16b	. Kind of Business Industry Health Care
ryland	ould be filed d Mental Hy marked ott matic event	To Be	17. Father's Name (First, Middle, Last) Albert Mercer Williams 19a. Informant's Name/Relationship (Type, Print) 19b. Ma	Margi	e (First, Middle, Maide Le Lee Sim	mons
re, Ma	l and 2 sho f Health an tem 27 is other trau		Barbara J. Lannen (Daughter) 24. 20a. Method of Disposition 20b. Place of Disp	iling Address (Street and Number or Rura 33 Harkins Road Wh position (Name of	nite Hall,	Maryland 21161 Location - City or Town, State
Baltimore,	mit. Page laartment of ortant: If i injury or e.		4 □ Donation 5 □ Other (Specify) Bel Air	Mem. Gdns. 3/23,	/2012 В	el Air, Maryland
B	permi Depar Impoi any in	(4)	23a. Part 1. Enter the disease, or complications that caused the death. Do not en	22. Name and Address of Facility Duda—Ruck Funeral I	dalk, Mar	
% 09	Ph. sician/ Medical Examiner the burial-transit	dical Examiner	shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):	Hert failure Hout Disease		Interval Between Onset and Death
. Box 687	ne death certifica r the attending posted for use as t	Completed by Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown 23c. If yes, outcome of pregnancy 1 ☐ Live Birth 2 ☐ Fetal death 3 4 ☐ Pregnant at time of death 5	☐ Ectopic pregnancy ☐ Other (specify)		23d. Date of delivery Month Day Year
'ds, P.O.	requires that the des been signed by the s should be detached i	ted by Pr	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.		o use contribute to the cause of death?
of Vital Records,	hysician: The law re his certificate has be I director, page 2 sh		25. Was case referred to medical		24a. Was an autopsy performed?	
Vita	nysicia nis certi directo	To Be	examiner? 1	26. Place of Death (Check		6 ☐ Other (Specify)
Division of	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours afferd death. To the Funeral Director, Affer this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transi	Certificate:	27. Manner of Death 1 Matural 5 Pending 2 Accident Investigation 3 Suicide 6 Could not be determined 4 Homicide Could not be building, etc. (Specify)	work? M 1 ☐ Yes 2 ☐ No	28d. Describe how inj 28f. Location (Street a City or Town, Sta	and Number or Rural Route Number,
_	To the Hospita within 24 hours To the Funeral completed filled	Medical	29a. Certifier (Check 2	estigation, in my opinion, death occurred at death occurred at the time, date and place	the time, date and pla e, and due to the caus	ice, and due to the cause(s) and manner stated e(s) and manner as stated.
•	7. × × 000		1/1/1	29c, License number DGB235	29d. [Date signed (Month, Day, Year) March 19, Sold
	10		30. Name and address of person who completed cause of death (Item 23a) (Type, 520 Web 2004) 31. Date filed (Month Page, Year) 32. General's Signature)r. Bel Air, N	10 210	214
	Stat	e	31. Date filed (Month Dex. War) 32. leg-strar's Signatur	ale		

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ March 2012 1740 Hoff Ethel Marie Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Carroll Hospice- Dove House Westminster Carroll 5. Social Security Number 8. Date of Birth (Month, Day, Year) If Under 24 Hrs Birthplace (State or Foreign Country) **Funeral** 7. Age (In yrs. last birthday) If Under 1 Year Months Hours 214-28-0762 Director 1 🗆 M 2 🔀 F 80 6/1/1931 Maryland Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director Carroll Westminster 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral United States 4535 Salem Bottom Rd. 21157 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. "natural", or 1 Never Married 2 Married ģ Yes Yes, Give 72 hours after Baltimore, Maryland 21215-0036 1 Yes 2 X No Specify: Completed 3 XWidowed 4 ☐ Divorced White Year or Dates or other traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) 2 should be filed within 7 th and Mental Hygiene. other than Elementary/Secondary (0-12) College (1-4 or 5+) Home Maker her home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Helen Irene Burdette Alvie E. Franklin 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau 3015 Salem Bottom Rd. Westminster, MD 21157 Brenda Hoff (Daughter) 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 💹 Burial 2 🗆 Cremation 3 🗆 Removal from State cemetery, crematory or other place) 4 Donation 5 Other (Specify) Salem Cemetery 3/19/2012 Westminster, MD Signature of Funeral Servi 22. Name and Address of Facility Burrier-Queen Funeral Home & Crematory, 1212 W. Old Liberty Road Winfield. Md or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, 23a. Part 1. Enter the disease, Approximate Interval Between shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death Gastrointestinel Physician/ Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to for as a consequence of Cause (Disease or injury that initiated events Due to (or as a consequence of) resulting in death) Last physician Physician/Medical that the death certificate be Division of Vital Records, P.O. Box 68760 the as ding IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 month Month Day 4 ☐ Pregnant at time of death g ☐ Unknown g 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Hospital or Attending Physician: The law requires Completed 1 Yes 2 No 3 Probably 4 Unknown Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 1 Yes Yes 25. Was case referred to medica Be 26. Place of Death (Check only one) Hospital Other: 1 Tyes ٩ 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 Inpatient 3 Inpotent 2 Inpatient 3 Inpotential 2 Inpatient 3 Inpotential 2 Inpatient 3 I funeral 27. Manne Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred HOWE 5 Pending Natural injury work? ours after death.

leral Director: Ai

filled in by the fu Accident
Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 - Homicide determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29d. Date signed (Month, Day, Year)

Registrar

DHMH 17 Rev 06-2011

State

31. Date filed (Month, Day, Year)

Name and address of person who completed cause of death (Item 23a) (Type, Print)
R. Raman B. Kaneng, 349 Males Im cleine wentminter

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Reg. No. Registrar 2. Date of Death 1. Decedent's Name (First, Middle, Last) Physician/ Month Day March 12, 2012 0856 hrs **Medical Examiner** Lvdia 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 3511 Greenmount Avenue Baltimore 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or 5. Social Security Number If Under 1 Year If Under 24Hrs. Age (In yrs. last birthday) **Funeral** Director Feb. 11,1970 MD285-74-1351 2 X F 42 Country) 1 M Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits or 28a-f show 1 Yes 2 XNo s 23a or 28a-f show Dunda1k Baltimore hours after death with the Maryland 10g. Citizen of What Country? 10e, Street and Number 10f. Zip Code 靣 11 Township Road 21222 United States Funeral 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, 11. Marital Status If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Armed Forces? White, etc. 1 X Never Married 2 Married 2 X No Yes f Yes, Give Year or Dates: 1 Yes 2 No specify: Specify: 3 Widowed 4 Divorced White <u>۾</u> 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) should be filed within 72 l and Mental Hygiene. Baltimore, MD 21215-0036 Cosmetology Cosmetologist 12 Years 18 Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ent of Health and Mental Hy nt: If item 27 is marked o æ Nancy Ellen Fenton Earl Edwin Hax. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Dundalk, Maryland 11 Township Road Nancy Ellen Clayton (Mother) 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, Date 20c. Location - City or Town, State crematory or other place 1 Burial 2 X Cremation 3 Removal from St 3/15/2012 Towson, Maryland Hilltop Service Corp. Denation 5 Other Specify: 22. Name and Address of Facility Duda-Ruck Funeral Home of Dundalk, 7922 Wise Ave. Dundalk, Maryland the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart art I. Enter the disease, or complications the rad Approximate Interval Physician Between Onset and failure. List only one cause on each line /Medical Death a.Combined toxic effects of methadone and cocaine Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Due to (or as a consequence of) if any, leading to immediate cause. Enter Underlying Cause Examine (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last executed attending physician and or use as the burial - tran Physician/Medical AMENDED 23a, 27, 28a-f, per me, g925 3-23-12 sm W UNPENDED to the Hospital or Attending Physician: The law requires that the death certificate be Box 68760 23d. Date of delivery IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the 1 Live birth 2 Fetal death 3 Ectopic pregnancy Month Year Day past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 ✓ Unknown 9 Unknown P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ 1 Yes 2 No 3 Probably 4 ✔ Unknown Completed Division of Vital Records, 24b. Were autopsy findings available autopsy prior to completion of cause of has 2 s performed death? certificate h ector, page 1 🗸 Yes Yes 2 No 2 No 26.Place of Death (Check only one) 25. Was case referred to medical å Other Nursing Home 5 Residence 6 Other: Scene Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA this 1 🗸 Yes မ 2 No 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred After Certification: 1 Natural unknown 1 Yes 2 X No 5 Pending death. the fd 3-12-12 fd 8:15 am 2 Accident Investigation þ 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3511 Greenmount Ave within 24 hours after d To the Funeral Direct 28e. Place of Injury - At home, farm, street, factory, office building, etc. 3 Suicide Could not be determined Residence 4 Homicide Baltimore, MD. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completely Medical 2 Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier O.C.M.E March 13, 2012

State Registrar

ORIGINAL

Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223

2012

Melissa Brassell, MD

30. Name and address of person who completed cause of death (Item 23a)

32. Registra s Signa

•			Plea	se Type								-		_	ble.	
	1	For State Registrar		State	e ot IVI	arylan		artmen <i>tificate</i>			and iv	1ental Hy	gien Reg. N	20	12	08809
Physician Medica		1. Decedent's Name	e (First, Middle,		Virgii	nia Ha	ırdesty					2. Date of De Month March		r8	Že ^a 12	3. Time of Death 3:45 A M
Examine		4a. Facility Name (if Mays Ch		give street and e Assisted		,		4b. City,	Town, or	Location o			4	c. County o	f Death Baltir	nore
Funeral Director		5. Social Security No. 215-10-0 Usual Residence of	0031	6. Sex 1		e (In yrs. Ia	ast birthday) Yrs.	If Under Months	1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of Bir (Month, Da 06/2		19	9. Birthp Count	lace (State or Foreign Naryland
faryland 3a-f show tifled at	ector	10a. State MD	10b. County	Baltimore		10c. Cit	y, Town or Lo	cation		Timor	nium				10	0d. Inside City Limits
with the N s 23a or 28 ust be no	Funeral Director	10e. Street and Num 12261 R		l Road, #3	14			10f. Zip	Code	2109	93		10g. C	Citizen of W	hat Count	
or mir	≥	11. Marital Status 1 □ Never Marr 3 Ⅸ Widowed		ied 1 1 1	d Forces? Yes 2 X	Ever in U.S No	- 1	Vas Deced f Yes, spec				cify Yes or No- Rican, etc.)		14. Race Black Specify:	, White, e	
thin 72 hour sne. than "natu ne Medical	Completed	(Spe	ecify only higher ondary (0-12)	t's Education st grade comple Colleg	ted) ge (1-4 or	5+)	16a. Deced (Give I life. De	kind of wor O NOT use	k done d retired)			ing	16b.	Kind of Bus		nistration
ibe filed wi lental Hygie rked other iic event, th	αri	17. Father's Name (ast) George	e Jorda	n			usines			e (First, Middle,			2 KGIIIII	misu acton
nd 2 should ealth and N n 27 is ma er traumat		19a. Informant's Na Kay Harde			hter			-				Route Number			ate, Zip C	iode)
t. Page 1 ar tment of H tant: If iter ijury or oth		4 Donation	Cremation 5 ☐ Other (S)		rom State		Place of Dispo emetery, cren Chesapea	natory or o ike Cre	ther place mator	у	3/20	0/2012	20c. 1	Location - C Bel	City or Too tsville	
permit Depar Impor any in		21. Signature of Full Dorota Ma	/	Sensee	_Vl	Laish	10	. Name an Maryla				vices, PO	Box 1	1413 Ba	ltimor	re, MD 21203
Physician/		23a. Part 1. Enter t shock, or hear Immediate Cause (disease or condition resulting in death)	rt failure. List o (Final	complications to			h. Do not ente	er the mod	e of dying	g, such as	cardiac c	or respiratory a	rrest,			Approximate Interval Between Onset and Death
Medical Examiner	er	Due to (or as a consequence of):														
e = = = = = = = = = = = = = = = = = = =	causé. Enter Underlying Causé (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):															
tificate b ng physic as the b	Medic	IF FEMALE:		d												
To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physici completely filled in by the funeral director, page 2 should be detached for use as the bu	Pnysician/Medic	23b. Was decedent in the past 12 1 Yes 2 1 9 Unknown	months? No	4 🗆 I	_ive Birth	of pregna 2 Feta at time of c	al death 3	Ectopic p Other (sp		у				23d. Date Mont		ry Day Year
quires that the signed by build be deta	음	Part II. Other signif	ficant conditio	ns contributing	to death b	out not res	ulting in the u	nderlying o	ause giv	en in Part	l.					e cause of death?
The law rec cate has ber , page 2 sho	Completed											24a. Was auto perfo 1 \square Yes		pri de	ere autop ior to con eath? Yes	sy findings available inpletion of cause of
ysician. is certifi director	o Be	25. Was case referred examiner?		Hospital:	I □ Inpat	ient 2 🗌	ER/Outpatier	nt 3 🗆 D0	Othe	ace of Dea		only one) me 5 \square Resi	dence	6 XOther	(Specify)	Assisted
tending Ph leath. or: After thi the funeral	Certificate:	27. Manner of Death 1 Natural 2 Accident 3 Suicide	h 5 Pendin Investig 6 Could r	g 28a. E	ate of inju Month, Da	ıry y, Year)	28b. Time of injury	M 2	8c. Injury work 1 🗆	at		28d. Describe				Living
oital or Att	al Cerr	4 Homicide	determi	ned 28e. P	uilding, et	c. (Specify						City or To	vn, Stat	e)		Route Number,
the Hosp nin 24 ho the Fune npletely f	Medical	(Check 2 only one) 3	☐ Medical E ☐ Certifying	Physician: To t xaminer: On the Nurse Practition	basis of e	examination	n and/or invest	tigation, in death occ	ny opinio urred at th	n, death o ne time, da	ccurred at	the time, date	and place the caus	e, and due t se(s) and ma	to the cau	se(s) and manner stated tated.
To with		29b. Signature and	an 84	ach	MI	>		1	License	6119	9		Mo	ate signed (19,	2012
21		30. Name and address	ess of person v	MD,67	cause of c	leath (Item	23a) (Type, Farles).	Print)	vite	410	Sili	inson.	MI) 2/2	204	1
State Registra		31. Date filed (Mont.	th, Day, Year) 1 2012	MD, 67	2. Registr	ar's Signat	ture									

12-02098				e ink. Ensure All Cop		gible.	
Tammy Jones		State of I		t of Health and Mental	Hygiene		
		Registrar	Certificate	of Death		Reg. No.	2 088
Physicia Medical Examin		Decedent's Name (First, Middle,Last)	Tango		2. Date of Dea Month March 13	Day Year	3. Time of Death 0825 hrs
,		4a. Facility Name (if not institution, give stre	et and number)	4b. City, Town, or Location of De		4c. County of Deat	
		2326 Bryant Avenue	,	Baltimore		NI	
Funeral		Social Security Number 6. Sex	7. Age (In yrs. last birthday			rth(MM/DD/YYYY) 9. Bi	thplace (State or
Director		217-72-6391 1 M	2VF 44	Yrs. Months Days Hours I	Vin. Dec. 1.	8, 1967 Forei	puntry)
		Usual Residence of Decedent				<u> </u>	19(5)
w any		10a. State 10b. County	10c. City, Town or L				10d. Inside City Limits
yland -f she	to	MD Baltim	ore CI	nase			1 Yes 2 No
ne Maryland or 28a-f show fied at once.	Director	10e. Street and Number	0.1	10f. Zip Code	11	log. Citizen of What Cou	ntry'?
ith th	a D	11. Marital Status 12.	Was Decedent Ever in U.S. 13.	Was Decedent of Hispanic Origin?	(Canaify Vac as No	<u> </u>	iona la dina Disala
eath w	Funeral		Armed Forces?	If Yes, specify Cuban, Mexican, Pue		White, etc.	ican Indian, Black,
fier d		3 Widowed 4 Vivorced If Yes	Yes 2 No 1	Yes 2 No specify:		Specify: R	lack.
ours a	d by	15. Decedent's Education (Specify only hig	hest grade completed) 16a. Dece	edent's Usual Occupation (Give kinding most of working life. DO NOT use		16b. Kind of Business/	Industry
6 12 h	lete	Elementary/Secondary (0-12)	ollege (1-4 or 5+)	- 1	retired)	A A .	
within giene.	Completed	10	2 (0)		nician	Medi	ical
MOre, MD 21215-0036 Pages I and 2 should be filed within 72 hours after death with the Maryland tent of Health and Mental Hygiene. Int: If item 27 is marked other than "natural", or items 23a or 28a-f sho or other traumatic event, the Medical Examiner must be notified at once.	Be C	17. Father's Name (First, Middle, Last)	uhand	18.Mother's Na	me (First, Middle, I		
212 uld be Ments mark	To B	19a. Informant's Name/Relationship (Type, F	Ynana 19b. Ma	ailing Address (Street and Number		n Lncy	Zip Code)
MD 12 sho th and 27 is umati		Renee. M. J.	ones 26	0	clo C	hase Mi	21220
ore, MI ss I and 2 s of Health a If item 27		20a. Method of Disposition	20b. Place of Dis	sposition (Name of cemetery.	Date	20c. Location - City or	
TOF Pages ent of nt: If		1 Burial 2 Cremation 3 Re 4 Dopation 5 Other Specific	emoval from State Crematory of King	r other place) Park	30/20	Pathing	a MD
Baltimore, MD 21215-00; permit. Pages I and 2 should be filed with Department of Health and Mental Hygiene Important: If item 27 is marked other tinjury or other traumatic event, the Med.		21 Stor ature of Funeral Se ice censee	1 WSOCI	2. Name and Address of Facility	tornell	FILMEN	20 Horas
	1	silan h	Invilla.	4600 Liberty	Heigh	ts Aug. Bx	attimore MI)
Physician /Medical		23a. Part I. Enter the disease, or complication failure. List only one cause on each line		ter the mode of dying, such as counta	c or respirately arre	est, shock, or feart	Approximate Interval Between Onset and
Examiner				zolpidem and levet	iracetam)Intoxication	Death
- Landon		b	o (or as a consequence of):				
	늘		(or as a consequence of):				
	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated	(or as a consequence of):				
		events resulting in death) Last Due to	(or as a consequence or).				
	Eal	X UNPENDED X AME	NDED 23a, 27, 28a-f,	per me g925 3-23 5.4/11/2012.WS	-12 sm		
Box 68760, : death certificate be ex the attending physician ed for use as the burial	Physician/Medic	IF FEMALE: 230	#ZUD.DETFH.G9Zt If yes, outcome of pregnancy	5.4/11/2012.WS		23d. Date of delivery	,
x 687 h certificending	ian	23b. Was decedent pregnant in the past 12 months?	Live birth 2 Pregnant at time of death	Fetal death 3 Ectopic preg	nancy	Month [Day Year
SOX leath of atter for us	ysic	1 Yes 2 No 9 V Unknown 9	Unknown	Other (Specify)			
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be exwithin 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician completely filled in by the funeral director, page 2 should be detached for use as the burial.		Part II. Other significant conditions contr	buting to death but not resulting in t	he underlying cause given in Part I.	23e. Did to	bbacco use contribute to	the cause of death?
Division of Vital Records, P.O. tal or Attending Physician: The law requires that the safter death. al Director: After this certificate has been signed by led in by the funeral director, page 2 should be detactly	힐				1 Yes	2 No 3 Prob	ably 4 🗹 Unknown
ords, w requir	Completed				24a. Was a		topsy findings available
e law te has	Ę				autop perfor 1 ✓ Yes	rmed? death?	ompletion of cause of
ital Recient: The sector, page	ပ္တု	25. Was case referred to medical		26.Place of Death (Chec		2 No 1 Y∈	s 2 No
Vita ysicia his ce direct	To Be	examiner? 1 ✓ Yes 2 No	1: 1 Inpatient 2 ER/Outpat	100		Residence 6 🗸 Other	: Scene
ding Ph		27. Manner of Death	Ba. Date of Injury (Month, Day, Year) 28b. Time	of Injury 28c. Injury at Work?	28d. Describe h	now injury occurred	
ion teath. tor: /	Certification:	Natural 5 Pending		15 am 1 Yes 2 X No	subject	ingested a	lcohol and
Division pital or Attencours after death teral Director: filled in by the	흷	3 Suicide 6 Could not be 2	8e. Place of Injury - At home, farm, s	street, factory, office building, etc.	28f. Location (S	Street and Number or Ru tate) 2326 Brya	ral Route Number, City
Spital nours filled	Š	Tiornicide	Specify) Reside		Baltimo	re,MD.	ane Ave.
To the Hos within 24 h To the Fur	g			ccurred at the time, date and place, a igation, in my opinion, death occurred			
Tot with Tot	Medical		nanner stated.	29c. License number		29d. Date signed (Mor	
	-	D A	200.	O.C.M.E.		March 14, 2012	, Day, (Gal)
	-	30. Name and address of person who comple	ted cause of death (Item 23a)				
			Assistant Medical Examiner	900 W. Baltimore Street,	Baltimore, MI	D 21223	
Sta	172	31. Date filed (Month, Day, Year)	3 Registrar's Signature				

DHMH 17 Rev 1/2001 OCME 2006

Registrar

OCME

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month and 6 11:30 Veronica Johnson Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Prince George's Hospital Cheverly Prince George's 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Days Hours 219-64-7162 **Director** 57 1 □ M 2 🛛 F Washington, DC July 14 1954 Usual Residence of Decedent show must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director MD 28a-f Prince George's Upper Marlboro Yes 2 No 10e. Street and Number Ь 10f. Zip Code 10g. Citizen of What Country? Funeral 20774 23a 10133 Scotch Hill Drive USA items filed within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. 14. Race - American Indian. and Mental Hygiene.
is marked other than "natural", or itel
aumatic event, the Medical Examiner. Armed Forces?

1 Yes 2 X No
If Yes, Give
Year or Dates. Black, White, etc. 1 X Never Married 2 Married ð altimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify. Completed 3 Widowed 4 Divorced Specify: Black 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 2+ Fragrance Model Private Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be.
Department of Health and Mental Important; If item 27 is manany injury or other. ည Clarence E. Johnson Sr. Margaret Martin 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7012 Farragut Street, Hyattsville, Maryland 20784 Margaret Johnson/ Mother 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State Harmony Cemetery 03/20/2012 4 ☐ Donation 5 ☐ Other (Specify) Landover, Maryland Signature of Funeral Service Licensee 22. Name and Address of Facility J. B. Jenkins Funeral Home Daphney 7474 Landover Road, Landover, Maryland 20785 23a. Part 1. Exter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph_sician/ Atheroset Cardiovese disease or condition resulting in death) Medical Examiner Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Exami To the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or injury that initiated events burial-tran physician and Due to (or as a consequence of): resulting in death) Last Physician/Medical P.O. Box 68760 the attending plant of the last as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Year Day the a Pregnant at time of death 2 No Unknown 9 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, Completed 1 Yes 2 No 3 Probably 4 Onknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s has performe this certificate 1 Yes 2 No Yes 2 - No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: 2 No Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify, 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at within 24 hours after death.

To the Funeral Director: After to completely filled in by the funer. 28d. Describe how injury occurred 1 Natural work?
1 \(\sum \) Yes 2 \(\sum \) No 5 Pending injury 2 Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check 3 🗆 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

State Registrar SMVA 40 r

MAR 21

3001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

vesTer

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar amend 8 per bc per kh g925 Cad 256 cate ok Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Year 13:23 PM Baby Girl Jones 2012 March Medical 4a. Facility Name (if not institution, give street and number) Examiner City, Town, or Location of Death 4c. County of Death HOPKIN Iti more + If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🖔 F Min. 10 Months Days Hours 3/1/12 Day, Year) Country) Maryland **Director** INFANT Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits filed within 72 hours after death with the Maryland Director 1 ☐ Yes 2 ✓ No MD Harford Edgewood 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1931 Edgewater Dr #J 21040 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2X No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14 Race - American Indian . 0 Black, White, etc. 1 Never Married 2 Married Completed by 1 Yes If Yes, Give Baltimore, Maryland 21215-0036 black 1 ☐ Yes 2 X No Specify: "natural", 3 Widowed 4 Divorced Year or Dates 27 is marked other than "natu traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) INFANT Page 1 and 2 should be filed within nent of Health and Mental Hygiene. ant: If item 27 is marked other tha INFANT INFANT INFANT Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Jeramae Huntley Tae'helene Jones 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, $1931\ Edgewater\ Dr\ \#J\ Edgewood\ MD\ 21040$ Tae'helene Jones - mother item 2 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Durial 2 Cremation 3 Removal from State Important: I any injury or 4 ☐ Donation 5 ☒ Other (Specify) in state Signature 10000 22. Name and Address of Facility State Anatomy Board 655 W. Baltimore St; Baltimore, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final Interval Between Onset and Death Physician/ Xtreme disease or condition resulting in death) rematurit Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed the attending physician and hed for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?

1 Yes 2 No Month Day Year 1 Yes 2 Unknown director, page 2 should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 ☐ Probably 4 ☐ Unknown 1 🗌 Yes Were autopsy findings available prior to completion of cause of death?

1
Yes 2
No 24a. Was an this certificate has autopsy perform Yes 2 Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No မ 1 XInpatient 2 ☐ ER/Outpatient 3 ☐ DOA within 24 hours after death.

To the Funeral Director: After thi
completed filled in by the funeral of 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 1 ∐ Yes 27. Manner of Death 28b. Time of Certificate: 28d. Describe how injury occurred 1 Natural 2 Accident injury 5 Pending 2 No Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical 29a, Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 🗆 only one Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 03.01.2012

State Registrar

30. Name and addr

31. Date filed (Month, Day, Year)

. Ducie

person who completed cause of death (Item 23a) (Type, Print)

-000

600 North Wolfe Street

Hopkins Hospital

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death February 29, Physician/ 20T2 10:25 AMM Mary A. King Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore Middle River 723 Kingston Road If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth Social Security Number 7. Age (In yrs. last birthday) **Funeral** Min (Month, Day, Year) Director 76 218-34-2003 1 M 2 X 1935 Maryland Aug 29, Usual Residence of Decedent show 10d. Inside City Limits 10b. County 10c. City, Town or Location ral", or items 23a or 28a-f sho Examiner must be notified at Director 1 Yes 2 No Middle River MD Baltimore Citizen of What Country? 10e. Street and Number 10f. Zip Code Funeral 21220 723 Kingston Rd. death v 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian 11. Marital Status Black. White, etc. "natural", or Completed by 1 Never Married 2 Married 1 Yes : 2 X No Baltimore, Maryland 21215-0036 hours after 1 ☐ Yes 2 🛣 No Specify. Specify: white 3 😱 Widowed 4 🗌 Divorced Year or Dates Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical I 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4 or 5+) Elementary/Secondary (0-12) own home housewife Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Emma Jane Steger Elisha Joshua Grothe 19a. Informant's Name/Relationship (Type, Print) Mailing Address (Street and Number or Pural Route Number, City or Town, State Zip Code, 723 Kingston Rd; Middle River, MD 21220 Robin Gocdwin - daughter 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place, 1 Burial 2 Cremation 3 Removal from State 4 X Donation 5 Other (Specify) e of Freral Service L Ron 1d 22. Name and Address of Facility State Anatomy Board 655 W. Baltimore St; Baltimore, MD 21201 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ Chronic disease or condition resulting in death) Medical **Examiner** steonovelin Sequentially list conditions If any, leading to immediate cause. Enter Underlying Exami Cause (Disease or injury that initiated events The law requires that the death certificate be executed the burial-tran Due to (or as a consequence of): resulting in death) Last attending physician for use as the buria Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No Month Day Year Pregnant at time of death
Unknown ed by the a detached 1 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 XYes 2 □ No 3 □ Probably 4 □ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy performe Yes 2 No 1 Yes 2 No To the Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital 2 No 1 Tes ဂ္ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 🗶 Residence 6 ☐ Other (Specify) 24 hours after death.

Funeral Director: After this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 1 Z Natural 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Certificate: 5 Pending injury 1 Yes Accident Investigation 2 Accident
3 Suicide
4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier Check

Registrar DHMH 17 Rev 06-2011

State

within 2 To the I

only one 29b. Signature ar

EBASTIAN

3023

0,0

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

Eastern

0005517

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 🤈 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 03 2012 Mildred Kadyszewski 06:05 pM Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Baltimore Oak Crest Care Center Baltimore If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 5. Social Security Number Funeral 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign (Month, Day, Year) 10/25/1920 166-14-3576 Country) 91 Director 1 🗆 M 2 F PA show 10a. State notified at 10c. City, Town or Location Director 10d. Inside City Limits 28a-f MD Baltimore Bàltimore 1 Yes 2 X No ō 10e Street and Number 10f. Zip Code Lark's Landing ed other than "natural", or items 23a or event, the Medical Examiner must be 10g. Citizen of What Country? Funeral 8800 Walther Blvd. Unit 329 S. U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify Completed 3 X Widowed 4 Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) and Mental Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) 12 Teacher Education Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Andrew Wargo Helen injury or other traumatic Orzehoski 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If item 27 is any injury or other tra Marianne Kadyszewski, Dtr. 419 Regester Avenue, Baltimore, MD 21212 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 🕱 Burial 2 🗆 Cremation 3 🗆 Removal from State Parkwood Cemetery 03/21/12 4 ☐ Donation 5 ☐ Other (Specify) Baltimore, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Leonard J. Ruck, Inc. 5305 Harford Road, Baltimore, MD 21214 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Disease or Condition resulting in death) Approximate Interval Between Onset and Death Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, Examine if any, leading to immediate
Cause (Disease or injury
that initiated events Due to (or as a consequence of) resulting in death) Last Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months?

1 Yes 2 No
9 Unknown Day Pregnant at time of death Month Year 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by ASCVD Records, 2 3 Probably 4 Unknown 1 🗌 Yes 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy death? performe Yes 2 D 1 Yes 2 No To the Hospital or Attending Physician: Division of Vital Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital 2 No Other: မ Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA filled in by the funeral Certificate: Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) 1 Natural 5 Pending work? Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined within 24 hours To the Funeral Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one completed cause of death (Item 23a) (Type, Print) 8800 Walther Blud, Parkville MO 21234 State Registrar

1CADXS25WSK

Ó

_ For	Plea									II Copi e			gible.		
State Registrar						rtificat					Reg. No	00	112	0	2815
1. Decedent's Name	O A .	Last)	7	Ko	JCK	Į.			1	2. Date of D	Death D	8-2	012	3. Time	of Death
4a. Facility Name (if 7312 Ger		-			j	4b. City	, Town, or Dund	Location a1k	of Death		40	. County	of Death	1timo	re
5. Social Security No. 218-28-0	162	6. Sex 1 ☐ M 2	□VE	e (In yrs. Ia	st birthday) Yrs.	If Unde Months	Days	If Under Hours	24 Hrs. Min.	8. Date of B (Month, D	Day, Year)	31	Cour		e or Foreign
Usual Residence of 10a. State	10b. County			10c. City	, Town or Lo			<u> </u>							City Limits
MD		Ltimor	e		Dunda										Yes 2 XNo
10e. Street and Nun	^{nber} 2 German	. ш 41 1	Road			10f. Zi	p Code	2122	2.				What Cou	·	
11. Marital Status	. Germai		s Decedent 8	ver in II S	12	Was Doco	dent of Hi			cify Yes or No	•		1 Sta	tes can Indian,	
1 X Never Marri		ed 1 [ned Forces?. Yes 2 X es, Give ar or Dates.	•No		If Yes, spe	cify Cuba	n, Mexicar	i, Puerto I	Rican, etc.)			ck, White,		
Elementary/Seco		st grade com		ō+)	life. D	kind of wo O NOT us	ork done d e retired)	ation Juring mos	t of workii	ng			usiness/In		7
12 Year					Ti	n So	rter							ustry	,
17. Father's Name (F Carl	Otto Ho	,	ch, Jr							(First, Middle rause	e, Maiden	Surnam	e)		
19a. Informant's Na Joan P.			ster)		19b. Mailii 4608	ng Addres Bea	s (Street a	ield	or Rura Driv	Route Numb ve Wh	oer City oi ite N	n ^{Town} , s	State, Zin	Code) 212	236
20a. Method of Disp 1 Burial 2 4 Donation	☐ Cremation	3 □ Remov pec <i>ify)</i> Ent	al from State	CE CE	ace of Dispo emetery, crer S • of	matory or o	other place	e) 1 •		Date / 2012				own, State Mary	Land
21. Signature of Fur	neral Service Li	censee								Home o					
23a. Part 1. Enter the shock, or hear immediate Cause (disease or condition resulting in death)	rt failure. List or Final				. Do not ente	er the mod	de of dying	g, such as	cardiac o		arrest,			Approxin Interval E Onset an	Between
Sequentially list cor if any, leading to im	nmediate //	b. —	Due to (or as	a conseque	ence of):									_	
cause. Enter Under Cause (Disease or i that initiated events resulting in death) L	injury	c	Oue to (or as a	a conseque	ence of):								-		
		L d													
IF FEMALE: 23b. Was decedent in the past 12 n 1 ☐ Yes 2 ☐ g ☐ Unknown	months?	1 4	es, outcome Live Birth Pregnant a Unknown	2 Fetal	death 3	Ectopic Other (s		у					te of deliv	ery Day	Year
Part II. Other sign ifi	icant condition	n s contributii	ng to death b	ut not resu	ulting in the u	underlying	cause giv	en in Part	I.					he cause o	f death?
										24a. Was auto perl	s an opsy formed?	24b.	Were auto prior to co death?	psy finding impletion o	s available
25. Was case referre	ed to medical						26 Pla	ice of Dea	th (Check		2 X N	0	1 U Yes	2 ⊔ No	
examiner?) No	Hospital	1 Innatio	ent 2 🗆 a	ER/Outpatier	nt 3 🗆 D	Othe			me 5 X Res	idence 6	S 🗆 🔿	or /Sacair	d	
27. Manner of Death 1 Natural 2 II Accident		7	Date of injury (Month, Day	ry :	28b. Time of injury		28c. Injury work?	at	2	me_5 X _1 Res 28d. Describe				0	
3 ☐ Suicide 4 ☐ Homicide	6 Could n determin	ot be	Place of Injubuilding, etc			eet, factor	y, office		1/2	28f. Location City or To			er or Rura	l Route Nui	mber,
29a. Certifier 1	ertifying l										cause(s) a	ind manr	ner as stat	ed.	

Certificate: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Physician/ Medical

Examiner

Funeral Director

a				
Medica	(Check 2 Medical Examine	ian: To the best of my knowledge, death or: On the basis of examination and/or invest Practitioner: To the best of my knowledge,	igation, in my opinion, death occurred at the	due to the cause(s) and manner as stated. time, date and place, and due to the cause(s) and manner stated and due to the cause(s) and manner as stated.
	29b. Signature and title of certifier	- ~	29c. License number	29d. Date signed (Month, Day, Year)
	100000	In mo	015872	March 20 20 12
	30. Name and address of person who cor	0 10 - 1 1 ×	Tint) Blud C	Jen Barino 21061
r	31. Date filed (Month, Day, Year) NAR 2 1 201	32 Registrar's Signature	all of	
				·

State

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 2012 SHIRLEY MARIE LENZ MARCH 14:47P Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Harford 506 Anchor Drive Joppa If Under 1 Year If Under 24 Hrs Months Days Hours Min. Social Security Number **Funeral** 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Months (Month, Day, Year) **Director** 219-26-3182
Usual Residence of Decedent 1 □ M 2**X**XF 76 Mar. 14,1936 Md. show Page 1 and 2 should be filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location must be notified at 10d. Inside City Limits Director 28a-f Maryland 1 Yes XX No Harford Joppa 5 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 506 Anchor Drive 21085 USA 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☒ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, o. þ Black, White, etc 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛛 No Specify: If Yes, Give "natural", White 3xx Widowed 4 □ Divorced Specify: Completed traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry
Baltimore County (Give kind of work done during most of working and Mental Hygiene. is marked other than life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Board of Education 12 yrs 6 yrs Music Teacher Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 William Henry Schiffler Anna M. C. Staehlin Schiffler 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau once. Kimberly A. Fox (Niece) 521 Elmwood Rd. Baltimore, Md. 21206 20a. Method of Disposition

1 ★ Burial 2 □ Cremation 3 □ Removal from State
4 □ Donation 5 □ Other (Specify) 20b. Place of Disposition (Name of 20c. Location - City or Town, State Immanuél Luth Ch.Cem. 3-24-2012 Baltimore, Md. g t re of Funeral Service Licensee 22. Name and Address of Facility Lassahn Funeral Home 7401 Belair Rd. Baltimore, Md. 21236 23a. Part 1. Enter the disease, or complications that caused shock, or heart failure. List only one cause on each line. , or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) or Attending Physician: The law requires that the death certificate be executed burial-trar that initiated events resulting in death) Last Due to (or as a consequence of) Completed by Physician/Medical Box 68760 the IF FEMALE: detached fir use 23b. Was decedent pregnant in the past 12 months?
1 Yes 2 No 23d. Date of delivery 5 Other (specify) Month Day Year Pregnant at time of death 9 Unknown Division of Vital Records, P.O. 2 Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? sign. 1 Ves 2 □ No 3 □ Probably 4 □ Unknown funeral director, page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: Other: 2 No 1 Tes မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred Director: After 1 Natural 5 Pending Accident the Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) within 24 hours a

To the Funeral C To the Hospital Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of cer 29d. Date signed (Month, Day, Year) 21128 Mo neygo State Registrar

				Pleas	se Type or							_		_	9.	
0			For		State o	f Marylar					and N	Mental Hy	/giene	001	0 0 0	17
W _			StateRegistrar				Cei	tificate	e of E	Death			Reg. No	201	2 000	1 /
7	Physicia		Decedent's Name Edwar	e (First, Middle, d Leroy	Last)							2. Date of Do		Year 201	3. Time of Dea	
A	Medic Examin		4a. Facility Name (if		give street and num	ber)		4b. Citv.	Town, or	Location	of Death	· Iak		. County of De		
	Admin	Ci	Upper	Chesap	eake Medi	cal Cer	nter		el A					Harfor		
7	Funeral		5. Social Security N			7. Age (In yrs. i		If Under	r 1 Year	If Under		8. Date of Bi	rth	9. B	irthplace (State or Fo	oreign
η	Director		217-5 Usual Residence	0-3515 of Decedent	1 🂢 M 2 🗆 F	66	Yrs.	Months	Days	Hours	Min.	Feb 26	, 194	46	^{country)} unk	
3	and show	ō	10a. State	10b. County		10c. Cit	ty, Town or Lo	cation							10d. Inside City Li	imits
3/13/12	Aaryk 8a-f tifiec	rect	MD	Har	ford		Havre d	le Gr	ace						1 🗆 Yes 2 🗓	X No
	the N	٥	10e. Street and Nun	nber		-		10f. Zip	Code				_	tizen of What C	Country?	
DOD	s 23s	Funeral Director		/2 Quar	ry Rd.			2	1078				US	SA		
Ã	death item		11. Marital Status	unk	12. Was Deced	dent Ever in U.	S. 13.	Vas Deced	dent of Hi	spanic Ori	gin? (Spe	cify Yes or No Rican, etc.)	-	14. Race - Am		
	", or	by	1 Never Marr		ed 1 Yes If Yes, Give	2 ∐ No	i	I X Yes	_					Black, Wh		
D 00	ours a tural	ted	3 Widowed	Charles and a	Year or Da											
2 - t	72 hc n "na ledio	nple			grade completed)		16a. Deced	ient's Usua kind of wor O NOT use	rk done a	uring mos	t of worki	ing	16b. K	ind of Busines	s/Industry un	13
<i>Bernard</i> d 21215-0036	ithin ene. r tha	Completed	Elementary/Seco unk		College (1-	_ ′	iiie. D	O NOT use	: retired)							
ard Be		To Be	17. Father's Name (110				18. Moth	er's Nam	e (First, Middle	, Maiden	Surname) u I	nk	
<u>~, ≥</u>	uld by Mer mark						T									
272	sho th and 7 is r		19a. Informant's Na			o.1 C+m	1	_						Town, State, 2		
5	and 2 Health em 2		20a. Method of Disp		ike Medica		Place of Dispo			nesa		Date DI, I		ocation - City o		
	age 1 int of t: If it		1 🗆 Burial 2	Cremation 3	Removal from	State C	cemetery, crer	natory or o	ther plac	e)		Date	200. E	Joddion Only	or rown, otate	
$g_{\rm h}$, $Ed\omega$	artme artme ortan injun				ecify) in et	ate	/ 22	Name an	nd Addrag	e of Facilit	tv C+	ate Ana		D 1		
eroy Bal	permit Depar Impor any in once.		21. Sign turn of Fu	1919 S	TARGE (1)	rector	- "								21201	
0)			23a. Part 1. Enter t	the disease, or o	omplications that c	aused the deat	h. Do not ente							OLE III	Approximate	
-1	Dhusieian/		shock or hear Immediate Cause (ly one cause on eac	ch line.	1 =	1.			-				Interval Between Onset and Deat	th .
	Physician/ Medical		disease or condition resulting in death)	in	a. Ath	or as a conseq	SCI er	OTH	U C	oro	Nou	yva	s Cu	IAR	UNKUO	MWN
, gor	Examiner				540 10 (01 40 4 0011004	401100 017.				-	dis	rea:	se		
		ner	Sequentially list co it any, leading to in cause. Enter Under	nditions,	b. Due to (ur de a consequ	uente on:	8								
	be executed sician and burial-transit	Examiner	Cause, Enter Under Cause (Disease or that initiated events	iniury	C											
	oe executed iician and burial-transi		resulting in death) I		Due to (d	or as a conseq	uence of):									
9	te be nysicia	dical			d										ļ	
876	tifical ng ph	Me	IF FEMALE:					-								
9 ×	h cer tendi or use	an/	23b. Was decedent in the past 12 r			Birth 2 🗌 Feta	aldeath 3			у				23d. Date of d	•	
Bo	deat he at hed fo	/sic	1 Yes 2 Duknown	No	4 ☐ Pregr 9 ☐ Unkn	nant at time of own	death 5 L	Other (sp	pecify)					Month	Day Year	
Ö	at the d by t letach	Completed by Physician/Medic	Part II. Other signif		s contributing to de	eath but not res	sulting in the u	nderlyina	cause div	en in Part	l.	23e Did	tohacco i	ise contribute	to the cause of death	12
<u>.</u>	es th signe	d by	77-6		- nelli			ا عا	2				Yes 2		Probably 4 ☐ Unki	
Ž.	equir	etec	2190	<u></u>	/ 0//1										autopsy findings avail	
ပ္တ	law r has b	mpl											s an opsy formed2		completion of cause	
ă	: The icate r, pag	ဝိ	05.14									1 ☐ Yes			es 2 🗆 No	
<u>=</u>	siciar certif irecto	Be	25. Was case referred examiner? 1 Yes 2	No	Hospital:	,			Othe	ace of Dea er:	`					
<u></u>	Phys r this	€ 100	27. Manner of Death		28a. Date of	npatient 2 of injury	ER/Outpatier 28b. Time of		DA !8c. Injury	4 □ N		me 5 Ll Res 28d. Describe		Other (Spe	ecify)	
u u	nding th. : Afte e fune	cate	1 Natural 2 Accident	5 Pending		h, Day, Year)	injury	М	work	? Yes 2□				,		
Sic	Atter r dea sctor by th	Certificate:	3 Suicide 4 Homicide	6 Could no	ot be 28e. Place	of Injury - At he	ome, farm, str	eet, factory	, office						Rural Route Number,	
Division of Vital Records, P.O. Box 68760	To the Hospital or Attending Physician: The law requires that the death certificate is within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physicompletely filled in by the funeral director, page 2 should be detached for use as the		4 El Homiciae	dotomin	buildin	ng, etc. (Specify	()					City or To	wn, State))		
	Hospital 24 hours Funeral etely fillec	Medical	29a. Certifier 2		Physician: To the besi										stated. e cause(s) and manner	r stated
	To the H within 2 ² To the F complet	Me	only one) 3		lurse Practitioner:			death occ	urred at th	ne time, da			the cause	(s) and manner	as stated.	
	8 9 Wit		29b. Signature and	une of certifier			TT		. License		25	- 0		te signed (Mor		
			2	year	1	1	مسلما	1.7	ノじ (, 5	>> ε	20	1101	-ch13	201Z	
			30. Name and addre	ess of person w		e of death (Iten	1 23a) (Type, F	rint)	500	24	FP	ورا	nes	مرح م	age in	11-
	Stat		31. Date filed (Mont	hDay, Year)	HOM T	egistrar's Signa	tue 1		15		VC.	160	M	IGN	X ZIO	4/
	Stat				1040 %.		A Asi	es Nad								

		For State Registrar		Certificate of L	Death		J. No. 201	2,08818			
Physicia Medic		1. Decedent's Name (First, Middle, La	,			2. Date of Death Month	Pay Year	3. Time of Death			
Examir		4a. Facility Name (if not institution, giv		4b. City, Town, or Bal H	r Location of Death		4c. County of Deat	N/A			
Funeral Director		220-54-7789	Sex 7. Age (In yrs. last birth		If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Yo July 20,	ear) Co.	thplace (State or Foreign untry) Yland			
faryland 8a-f show tiffed at	Director	Usual Residence of Decedent 10a, State Maryland Balti	more Roseda	or Location 1 e	1			10d. Inside City Limits 1 Yes 2 X No			
th with the Maryland ms 23a or 28a-f show must be notified at	Funeral Dir	10e. Street and Number 8107 Sumpter Av	enue	10f. Zip Code 212	37	10	g. Citizen of What Co	puntry?			
permit. Page 1 and 2 should be filed within 72 hours after death with the Manyland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at once.	þ	11. Marital Status 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Ever in U.S. Armed Forces? 1 IX Yes 2 No If Yes, Give Year or Dates. Vietnam	13. Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 🛛 No	ın, Mexican, Puerto		14. Race - Ame Black, White Specify: Wh				
thin 72 hou ene. than "nat the Medica	Completed	15. Decedent's (Specify only highest g	rade completed) College (1-4 or 5+)	Decedent's Usual Occup (Give kind of work done of life. DO NOT use retired) aintence	during most of worki	ng 16	Sb. Kind of Business/ Facility	/Industry			
be filed wi ental Hygie ked other ic event, tl	To Be (17. Father's Name (First, Middle, Last) George Hen			18. Mother's Name	e (First, Middle, Mai		5			
d 2 should aith and M n 27 is mar er traumat		19a. Informant's Name/Relationship (Bernadette Landg	1	Mailing Address (Street a			ty or Town, State, Zip Maryland				
Page 1 an nent of He ant: If iten ury or oth		20a. Method of Disposition 1 X Burial 2 Cremation 3 4 Donation 5 Other (Spec	Removal from State	Disposition (Name of y, crematory or other place SON Forest	:e)		oc. Location - City or Owings	Town, State Mills, MD			
permit. Departi Import any inji		21. Signature of Funeral Service Licer	extern de	22. Name and Addres	ss of Facility Ba . Ruck. I		Maryland Harford				
Physician/ Medical		23a. Part 1. Enter the disease, or complications that clused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause that line. Immediate Cause (Final disease or condition resulting in death) a. Due to (or as a consequence of):									
Examiner	er	Due to (or as a consequence of):									
ecuted and I-transit	zaminer	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c								
ate be ex ohysician the buria	dicall		■ d	,							
To the Hospital or Attending Physician; The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-trans	by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown 9 Unknown 23d. Date of December 2 23d. Date of December 2 23d. Date of December 3 Ectopic pregnancy 23d. Date of December 3 Ectopic pregnancy 23d. Date of December 3									
requires that the death been signed by the atter should be detached for	ed by Pr	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the significant conditions contribute to the significant conditions.									
The law rec cate has bee page 2 sho	Completed					24a. Was an autopsy performe	d? prior to death?	topsy findings available completion of cause of			
ician; certific rector,	Be	25. Was case referred to medical examiner?	Hospital:	Otho	ace of Death (Check						
ing Phys fter this uneral di	ate: To	1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending	1 Impatient 2 ER/Out 28a. Date of injury 28b. Telegraphics 26b. Telegraphics 28b. Telegraphics 28b. Telegraphics 28b. Telegraphics 28b. Telegraphics 28b. Telegraphics 28b. Telegraphics 26b. Te	me of 28c. Injury	4 □ Nursing Ho / at ?	me 5 Residence 28d. Describe how	e 6 Other (Specinjury occurred	ify)			
To the Hospital or Attending Physician; The law within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2.	Certificate:	2 Accident Investigation 3 Suicide 6 Could not lead to determined	be 28a Bloom of Injury. At home for		Yes 2 □ No	28f. Location (Stree City or Town, S	et and Number or Rui state)	ral Route Number,			
oita urs eral	ical	29a. Certifier 1 Certifying Phy	ysician: To the best of my knowledge, d	eath occurred at the time	e, date and place, ar	id due to the cause	(s) and manner as st	ated.			
ne Hosp in 24 ho ne Fune pletely i	Medical	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Description of the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Description of the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 Description of the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 Description of the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 Description of the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 Description of the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 4 Description of the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 5 Description of the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 5 Description of the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 5 Description of the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and death occurred at the time, date and place, and due to the cause(s) and death occurred at the time, date and place, and due to the ca									

State Registrar M.D.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Shelley Sahu MD 10 N. Greene Street Baltimore MD 71761

31. Date filed (Month, Day, Year)

MAR 2 1 2012

32 Aegistrar's Signature. DHMH 17 Rev 06-2011

NP1: 1184949646

March 18, 2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible

John Lockamy		I- For State	State	of Maryla	-	rtment o	f Health an	d Mental	Hygiene	910101	2011	2 0001
Physiciar	_	Registrar 1. Decedent's Name (First, N	liddle,Las	st)		incate of	Dealit		2. Date of Deal	∋g.No. (≟ th	<u> </u>	3. Time of Death
Medical Examin	er	Jehn 4a. Facility Name (if not insti	ution giv	C p	1ARles		LOCK A	AMY	Month March 18,	Day 7	Year ity of Death	1640 hrs
		Johns Hopkins Bay	view N	ledical Cente	эг		Baltimore					
Funeral Director		5. Social Security Number 215 80 176	6. S	ex 2	7. Age (In yrs. Ia	ist birthday) Yrs	Months Day		Min. Decemb	•	Foreign	nplace (State or ntry) Many land
any		Usual Residence of Deceder 10a. State 10b. Cou			10c. City,	Town or Locat	ion		00000	2,116		10d. Inside City Limits
yland f show	ខ្ពុ	MARYLAND BA	Ltir	10RE	De	NOALK				2 200		1 Yes 2 No
	Director	-701-1	Nel	1 ROAD	d		10f. Zip Code	22	10	og. Citizen of	S, A	7.
death with	Funeral	11. Marital Status 1 Never Married 2	Married		dent Ever in U.Sces?	5. 13. Wa	s Decedent of His es, specify Cuban	panic Origin? (, Mexican, Pue	(Specify Yes or No- erto Rican, etc.)		ace - Americ hite, etc.	an Indian, Black,
urs after d	≧ -	3 Widowed 4 55. Decedent's Education (If Yes, Give Year or Dates:		1	Yes 2 No		of work done	Specif	y: Whi	
nore, MD 21215-0036 ages I and 2 should be filed within 72 hours after no freath and Montal Hygiens. Effican 27 is marked other than "natural", other traumatic event, the Medical Examiner.	Completed	Elementary/Secondary (0-	10	College (1-		during m	ost of working life.	DO NOT use r				use
and 2 should be filed within 72 and 2 should be filed within 72 feet and Mental Hygiene. Traumatic event, the Medical		17. Father's Name (First, Mid	dle, Last)			,		18.Mother's Na	me (First, Middle, M	Maiden Surnar	me)	07
212. hould be and Mental is marken tic even	0 20	19a. Informant's Name/Relati		-	1		Ad ress (Stree	ELIZ and Number of	or Rural Route Num	ber, City or T	own, State,	Zip Code)
ore, MD es 1 and 2 sho of Health and If item 27 is ther tranmati	ŀ	20a. Method of Disposition	nith				ition (Name of cen	h Koac	Date	4/K, M 20c. Locatio	n - City or T	va 21222 own, State
		4 Donation 5 Othe	Specify:		117	rematory or oth	centory.	Inc. 2	18ch 13,2012	BALT		
		21. Signature of Funeral Sen	10	omac	ki	W.	ame and Advess Pabaea 25 Dund	SKI/CI	horarack BALTIA	10121	74RG [4	Mes P.A.
Physician /Medical	1	23a. Parl I. Enter the disease failure. List only one ca	use on ea	line.					c or respiratory arre		heart /	Approximate Interval Between Onset and Death
Examiner		or condition resulting in deat		Due to (or as a c			and Dia	<u>аеришу з</u>	Incontrac	1011		
		if any leading to immediate cause. Enter Underlying Cau (Disease or injury that initiate	d c.	Due to (or as a c	10,000						_ 1	
and and transit		events resulting in death) La		Due to (or as a c	onsequence of)	i -						
50, Control of the be executed by spician and burial - transi	Legical -	X UNPENDED			Ba, 27, 28		r me,g92	6 4–19-	-12 sm	22d Data	of delivery	
c 687(certifica ending ph use as the		3b. Was decedent pregnant in past 12 months?	n the	1 Live bin		2 Fe	ial death 3 [Ectopic preg	gnancy	Month	Da Da	y Year
the death		1 Yes 2 No 9	Unknown	9 JOHKHOW			nderlying cause gi	ven in Part I	23e. Did tot	pacco use cor	otribute to th	e cause of death?
S, P.C uires that n signed I									1 Yes	2 No		bly 4 🗹 Unknown
c law req	Completed by								24a. Was a autops perform	n <u>ed</u> ?	prior to cor death?	psy findings available inpletion of cause of
Triffica tor, pa		25. Was case referred to med	ical				26.Place	of Death (Chec	1 ✓ Yes 2 ck only one)	. No	1 Yes	2
f Vital Physician or this certi		examiner? 1 ✓ Yes 2 No	H	lospital: 1 🗹 Inp	oatient 2 🔲 E	ER/Outpatient	3 DOA	Other Nurs	sing Home 5 F	Residence 6	Other:	
1 Of ling P		27. Manner of Death 1 Natural 5		28a. Date of (Month, D	Injury (ay,Year)	28b. Time of Ir	4.11	at Work?	28d. Describe h			lications
Sior Attend death ctor: yy the		= ····· • □ P	ending vestigation			Ed 08:3	J pm.	es 2 🗶 No		_		dications
Division of Vital Records, P.O. Box 68760 To the Hospital or Attending Physician: The law requires that the death certificate the vithin 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physicompletely filled in by the funeral director, page 2 should be detached for use as the buckling of the state of the completely filled in by the funeral director, page 2 should be detached for use as the buckling of the completely filled in the funeral director, page 2 should be detached for use as the buckling of the completely filled in by the funeral director, page 2 should be detached for use as the buckling of the completely filled in by the funeral director, page 2 should be detached for use as the buckling of the completely filled in by the funeral director, page 2 should be detached for use as the buckling of the completely filled in by the funeral director, page 2 should be detached for use as the buckling of the completely filled in by the funeral director, page 2 should be detached for use as the buckling of the completely filled in by the funeral director, page 2 should be detached for use as the buckling of the completely filled in by the funeral director, page 2 should be detached for use as the buckling of the completely filled in by the funeral director, page 3 should be detached for use as the buckling of the completely filled in the funeral director.		4 Homicide	ould not le etermined	oe	Found: F		t, factory, office bu	iliding, etc.	or Town, Sta	treet and Num ate) 7920 re,MD.	Lynch	Route Number, City
To the Howithin 24 For the Four completely					examination and				nd due to the cause d at the time, date a			
		29b. Signature and title of cer	tifier			111	29c. License O.C.N			29d. Date sig		n, Day,Year)
Φ		30. Name and address of pers Russell Alexander M		completed cause	/ '/	, ,	N Baltimara	Street Polici	imore, MD 212			
Stat	e i	31. Date filed (Month, Day, Ye			strar's Signature		. Daminore (Dalli	IIIOIG, WID Z IZ	23		A SALVE
Registra		NAD 9 1 2012	_		1 he	ile						
DHMH 17 Rev 1/200 OCME 2006	1	HAIN & A COIL	M		7	ORIGINAL					OCME	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND TIEM#7perFH, G926, 4/19/2012, WS
State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death LEHNERT Day Physician/ SHIRLEY Month P Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Hospice of the Cheasapeake Linthicum Anne Arundel Social Security Number Age (In yrs. last birthday) If Under 24 Hrs Hours Min. 8. Date of Birth (Month, Day, Year, **Funeral** 9. Birthplace (State or Foreign Months Days 220-24-6230 Director 1 M 2 4 1930 July 22, Maryland Yrs. 81 Usual Residence of Decedent 28a-f show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "nature" any injury or other traumatic executions. 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD Anne Arundel Linthicum 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 6432 St. Philip Rd. 21090 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 11. Marital Status 14. Race - American Indian, Armed Forces?
1 ☐ Yes 2 🔀 No þ Black, White, etc. 1 Never Married 2 X Married 1 Yes 2 X No Specify: If Yes, Give Year or Dates White 3 Widowed 4 Divorced Specify: Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Grocery Store Meat Wrapper Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 George Yeager Amanda 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Nelson B. Lehnert (Husband) 6432 St. Philip Rd., Inthicum, MD 21090 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State Loudon Park Cemetery 3/22/12 Baltimore, Maryland 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licens 22. Name and Address of Facility Loudon Park Funeral Home 3620 Wilkens Ave., Baltimore, MD 21229 23a. Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury Due to (or as a consequence of): use as the burial-transi Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy
5 ☐ Other (specify) in the past 12 months? Day Pregnant at time of death Month Year P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ ₩hknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy death? performed' 1 Yes 2 L funeral director, 25. Was case referred to medical To Be 26. Place of Death (Check only one) examiner? Hospital 1 Yes Other: 2 140 ATE 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 ther (Sp 28c. Injury at work? 1 ☐ Yes 2 ☐ No 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28d. Describe how injury occurred OUSE 1 Natural 5 Pending injury Accident Investigation Director: Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 28f. Location (Street and Number or Rural Route Number, City or Town, State) ☐ Homicide determined To the Hospital within 24 hours a To the Funeral C Medical 29a. Certifier Effectifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 06-2011

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

amend #9 Per FH G926 4/20/2012 JH
State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2 1 2

			For State Registrar	State of Maryla	•	tificate of L		ivientai Hy	giene Reg. No.	012	08821
	Physicia Medi		1. Decedent's Name (First, Middle, Las Alp	honso Stever	Lignel	li		2. Date of De Month	eath Mar 17, 20	12 Year	3. Time of Death 6:00 P M
were.	Exami		4a. Facility Name (if not institution, give	street and number)		4b. City, Town, or	Location of Dea		4c. Cou	nty of Death Hov	vard
N.	Funeral Director		5. Social Security Number 579-46-3758 Usual Residence of Decedent	7. Age (In yrs.		If Under 1 Year Months Days	If Under 24 Hrs Hours Min		th 25, 1936	Count	place (State or Foreign ry) ngton, D.C.
	faryland Ba-f shov tified at	ector	10a. State 10b. County Ho	ward 10c. C	ity, Town or Loc	ation	Ellicott Ci	ty		11	0d. Inside City Limits 1 ☐ Yes 2 🛣 No
	with the N 23a or 2 ast be no	eral Di	10e. Street and Number 3583 Scheel Dr.	. J.		10f. Zip Code	21042		10g. Citizen	of What Coun	try?
9800	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	Completed by Funeral Director	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	If Yes, Give 10/	19/195 If	Vas Decedent of Hi Yes, specify Cuba ☐ Yes 2 X No	n, Mexican, Puer	pecify Yes or No- to Rican, etc.)		Race - America Black, White, e Bify: Whi t	etc.
21215-0036	thin 72 ho sne. than "na re Medic	Somple	15. Decedent's Eigenverte (Specify only highest grade) Elementary/Secondary (0-12)	ducation ade completed) College (1-4 or 5+)	(Give k	ent's Usual Occup ind of work done o NOT use retired) Pol i		rking		f Business/Inc	
and 2	oe filed wi ntal Hygie ced other cevent, ti	To Be (17. Father's Name (First, Middle, Last)	quale Carmen Ligi	nelli		18. Mother's Na	me (First, Middle,		ıme)	
Maryland	2 should ! Ith and Me 27 is mar! traumatia		19a. Informant's Name/Relationship (7) Elizabeth Lignelli Spe	pe, Print)	19b. Mailin	g Address (Street a Scheel Dr.	and Number or Re Ellicott City	ıral Route Numbe	er, City or Towr		ode)
Baltimore,	Page 1 and ment of Heal ant: If item ury or other		20a. Method of Disposition 100 Burial 2 Cremation 3 4 Donation 5 Other (Specification)	Removal from State	Place of Dispos cemetery, crem Gate of He	sition (Name of atory or other place eaven Cernete	ery Ma	Date r 22, 2012		on - City or Too	wn, State , Maryland
Balt	permit. Departimport any inj		21. Signature of Funeral Se e Lice s	he Bucht	22.	Name and Address Slack Fu 3871 Old	neral Home, Columbia P	P.A. ike Ellicott C	ity, MD 21	043	
	hydicium Medical Examiner		23a. Part 1. Enter the disease, or comp shock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)	olications that caused the dealer cause on each line. a. Debit Due to (or as a consection)	:ty	the mode of dying	g, such as cardia	c or respiratory ar	rest,		Approximate Interval Between Onset and Death
0		ledical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last	b. Due to (or as a consect. Due to (or as a consect.)						7+0	
. Box 68760	ith certific ittending for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregn 1 Live Birth 2 Fe 4 Pregnant at time of 9 Unknown	tal death 3 🗌	Ectopic pregnanc Other (specify)	у			Date of deliver	Y Day Year
ls, P.O.	uires that the dea n signed by the a uld be detached i		Part II. Other significant conditions co		sulting in the ur	derlying cause giv	en in Part I.				e cause of death?
Division of Vital Records,	The law require cate has been si page 2 should I	Completed by	1,					24a. Was autop perfo 1 Yes	osy rmed?	o. Were autop: prior to com death? 1 \(\subseteq \text{Yes} \) 2	sy findings available apletion of cause of
/ital	ysician: The is certificate director, pag	To Be	25. Was case referred to medical examiner? 1 Yes 2 No	Hospital:	ED/Outpationt	Othe	r: Che				
on of	nding Phy ath. : After this e funeral o		27. Manner of Death 1	28a. Date of injury (Month, Day, Year)	28b. Time of injury	28c. Injury work	at	dome 5 Residence 5			
		al Certificate:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At h building, etc. (Specif		et, factory, office		28f. Location (S City or Tow		ber or Rural F	Route Number,
	the Hospital thin 24 hours a the Funeral C	Medical	(Check 2 ☐ Medical Examin	ician: To the best of my knowner: On the basis of examinationer: To the best of	on and/or investig	ation, in my opinio	n. death occurred	at the time, date a	nd place, and o	fue to the caus	se(s) and manner stated
	To the within 2 To the comple		29b. Signature and title of certifier	hoed CR		29c. License			29d. Date sigr		ay, Year)
1	1		30. Name and address of person who co	ompliced cause of death (Iter	n 23a) (Type, Pr	Charles:	St. Ba	Himne	.mb 2	1204	
	Stat Registra		31. Date filed (Month, Day, Year) NAR 2 1 2012	32. Registrar's Signa	face	1		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		(•

			For State Registrar	State of N	Marylan		artment			and M	ental Hy	giene Reg. No	201	2	1882
	Physici	an	1. Decedent's Name (First, Midd	tle, Last)							2. Date of De Month		three and 1	3. 7	Time of Death
e.	/Medio		4a. Facility Name (If not institution	on give street and number	er)		4b City 1	Town or	Location o	of Death	_3_	16	. County of Dea	th	3 PM M
3	Examir	ier	POWERBACK	D. TILAA	חל אם	J	45. Oity,		HERV			1	BALTI		7
	Funeral		5. Social Security Number	6. Sex / 7.		last birthday)	If Under	1 Year	If Under 2		8. Date of Bir (Month, Da	rth		thplace (State or Foreign
П	Director		219-30-9849	1 2 M 2 □ F	80	Yrs.	Months	Days	Hours	Min.	10/18/	1931		ou'ntry) `	MD
	put N		Usual Residence of Decedent 10a. State 10b. Count		100 Cit	y, Town or Lo	cation							1404.1-	02 11 2
	shov shov	5		,	100. 010			_							side City Limits □Yes 2X No
	the N 28a-f notifie	Director	10e. Street and Number	TIMORE		BAL	TIMOR					10a Cit	tizen of What Co	L	
	with 3a or 1 be		32 GREENWIC	H DI ACE			101. 210		1208			rog. On		,	
	ms 2;	Funeral	11. Marital Status	12. Was Decede	nt Ever in U.	.S. 13.	Was Deced			gin? (Spec	cify Yes or No Rican, etc.))-	14. Race - Ame	SA erican Inc	lian,
9	filed within 72 hours after death with the Maryland Hygiene. ther than "natural", or items 23a or 28a-f show ant, the Medical Examiner must be notified at	E	1 ☐ Never Married 2☐XMa	Armed Force 1 XYes 2[If Yes, Give						i, Puerto F	Rican, etc.)	Ì	Black, Whit		
2-0036	ours iral",	d by	3 ☐ Widowed 4 ☐ Divorce	d Year or Date:	s:		1 ☐ Yes 2	□M 0	Specify:				Specify:	WHIT	Έ
3	"natu edical	Completed	15. Decede (Specify only high	nt's Education est grade completed)		16a. Deced	dent's Usua kind of work DO NOT use	Occupa k done d	ition <i>uring most</i>	of workin	ıg	16b. K	ind of Business	Industry	
127	withir ene. than	E G	Elementary/Secondary (0-12)	College (1-4o	or 5+)			e retired)	}						
2	be filed within 72 hours after death with the Marylar tital Hygiene. d other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	ပိ	17. Father's Name (First, Middle	. Last)		A	GENT		18. Mothe	r's Name	(First, Middle	. Maiden	INSURA	NCE	
Maryland 2	2 should be filed and Mental Hygi Is marked other aumatic event, t	To Be	ELI	LEVIN						DIE	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	,	ILVER		
ar∠	s 1 and 2 should f Health and Men item 27 Is marke other traumatic	-	19a. Informant's Name/Relation	ship (Type. Print)		19b. Mailir	ng Address	Street a			Route Numb		or Town, State,	Zip Code)
	and 2 salth a n 27 ls	1 3	DIANE LEVIN /	/ WIFE		32 G	REENW:	ICH :	PLACE	ВА	LTIMOR	Е, М	D 21208		
altimore,	ges 1 at of He If item or oth	1 3	20a. Method of Disposition 1 X Burial 2 ☐ Cremation	2 Domewal from Cha		Place of Dispo	sition (Nam	e of	1		ate		ocation - City or	Town, S	tate
Ĕ	nit. Pages artment of i ortant: If its Injury or o	138	4 Donation 5 Other (HAR	SINAI	BENEV	OLE	NT 3	/18/	2012	ROS	EDALE,	MD	
gall	permit. Depart Import any Inj once.		21. Signature of Euperal Service	Licensee		22	. Name and	Address				NSON	& BROS	., І	NC.
_	0 0 E 8 9		- Lega				900 RI			WN R	OAD P	IKES	VILLE,		
			23a. Part 1. Enter the disease, of shock, or heart failure. Lis	or complications that caus st only one cause on each	ed the death line.	h. Do not ent	er the mode	of dying	, such as	cardiac or	respiratory a	rrest,		Inter	oximate val Between et and Death
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	a		R4 70127	L 54	LUA	E					_5	DAYS
2	Examiner		,	Due to (or a	as a consequ	uence of):		III eegy o	-0.520		Λ Δ	2.000			
		e e	Se grentially list condition if any, leading to immediate	b. Due to (or a	as a consequ		rict i)	w.	OF	BILL	PER	DVVI	132	5	no
	uted d ansit	Examiner	Se prentially list condition if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	S		,									
o,	be executed ician and burial-transit	Exa	resulting in death) Last	Due to (or a	as a consequ	uence of):									
8/00	rate be executed hysician and the burial-transit	Ical		d											
0	requires that the death certificate een signed by the attending physi nould be detached for use as the		IF FEMALE:												
Z D D	death certifica attending pl	Physician/Med	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcom			Ectopic pre	anancv				10	23d. Date of de		
5	ie dez the at ned fo	sici	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnant 9□Unknown			Other (spe						Month	Day	Year
7	w requires that the de been signed by the should be detached	F.	Part II. Other significant condit	ions contributing to death	but not ree	ilting in the ur	derlying on	ueo aivo	n in Bort i		22a Did t	abanna	use contribute to	the one	on of dooth?
as,	signe d be o	by		to death	Dut not rest	and in the di	idenying ca	use give	ii iii i aiti.		1 🗆				4 □Unknown
ecords		etec								_					
Ě	The law ate has bo bage 2 sh	Completed				<u> </u>					24a. Was		24b. Were at prior to death?	atopsy fir completion	idings available on of cause of
		ပ္သ	25. Was case referred to medica								1□ Yes	2, No		2 🗆 N	10
>	nding Physician: th. : After this certifica s funeral director, p	o Be	examiner?	Hospital	tiont 2 🗆	ER/Outpatien	t 3 □ DOA	Otho	r.		(Check only o		a V au (2	D.	EIHNYS
ō	g Phy erthi	-1	27. Manner of Death	28a. Date of Ir	njury	28b. Time of		c. Injury Work			Bd. Describe		6 Other (Spe ry occurred	city)	באאי
VISIOII	ath. rr: Aft	atio	1 ☑ Natural 5 ☐ Pendi 2 ☐ Accident invest	ng <i>(Month, E</i> igation	Jay rear)	Injury	м		r es 2∐N	10					
<u> </u>	I or Attend after death. Director: /	Certification:	3 ☐ Suicide 6 ☐ Could 4 ☐ Homicide determ	nined Zoe. Place of I	njury - At ho etc. (Specify	me, farm, stre	eet, factory,	office		28	Bf. Location (Street an	nd Number or Ri	ıral Roui	e Number,
2	ital o rs aft ral Di led in	Se													
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director,	edical	Check only 2 Medica	ng Physician: To the bes I Examiner: On the basis	of examinat	wledge, death tion and/or inv	occurred a restigation,	t the time	e, date and inion, deat	d place, a	nd due to the	cause(s)) and manner as d place, and due	stated.	ause(s)
	thin 2 the omple	Med	one) 29b. Signature and title of certific	and manner s	stated.			License					te signed (Mont		
	Son With	_	VA TU)					130	i			3-16-12	n, Day,	ear
		-	30. Name and address of person	who completed sauce of	death /Ita-	23a) (Tunc 1		TO OK		1		1,	11012		
			Kathleen Tul	_ J				ე 1	202						
	Sta		31. Date filed (Month, Day, Year,	32. legic	mar's Signat	d. A	Lauu		202						
	Registr	ar	NAR 2	1 2012 Dans	m 1	5. Al	TUTO								

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. for State Registrar State of Maryland / Department of Health and Mental Hygiene Certificate of Death ent's Name (First, Middle, Last) 2. Date of Death Physician/ sadore Mog S 250 RI Medical **Examiner** 4c. County of Death BALTIMORE OVY last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** 9. Birthplace (State or Foreign Country) **Director** 215-16-0831 1 **X** M 2 □ F 89 01/20/1923 MD Usual Residence of Decede show notified at 10a. State 10b. County 10c. City, Town or Location Director 10d. Inside City Limits · 28a-f MD BALTIMORE BALTIMORE 1 Tes 2 X No 10e. Street and Number 10f. Zip Code r items 23a or iner must be r 10g. Citizen of What Country? Funeral 16 OLD COURT ROAD, 21208 USA be filed within 72 hours after death 12. Was Decedent Ever in U.S. n "natural", or iten ledical Examiner r Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Armed Forces? Black, White, etc. ģ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify Completed 3 Widowed 4 Divorced Specify WHITE the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. **I other than '** Elementary/Secondary (0-12) College (1-4 or 5+) SALESMAN INSTALLMENT other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental F မ Department of Health and Mont. Important: If item 27 is marked any injury or other. RUBIN LIEBOWITZ LIBE GOLDFINE 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) KAREN LIEBOWITZ/DAUGHTER SWAMPSCOTT COURT, APT. I, 21234 PARKVILLE, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 XBurial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) BETH EL MEMORIAL PK. 03/20/2012 RANDALLSTOWN, MD 21. Signature of Funeral Service Licen 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause or monine. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate Examiner Due to (or as a consequence of): Cause (Disease or injury that initiated events attending physician and Due to (or as a consequence of): resulting in death) Last Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Day Year Pregnant at time of death Unknown 9 🗌 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ò 2 No Completed 1 🗌 Yes 3 Probably 4 Unknown Were autopsy findings available 24a. Was an has autopsy prior to completion of cause of within 24 hours after deaun.

To the Funeral Director: After this certificate the managed with filled in by the funeral director, pag 1 Yes 2 No 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) 뎯 1 Tes Other: 28a. Date of injury
(Month, Day, Year) ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending 1 Yes 2 No Accident Investigation 3 Suicide
4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check only one) 3 🗌 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29d. Date signed (Month,

State Registrar ne and address of

DHMH 17 Rev 06-2011

ed cause of death (Item 23a) (Type, Print) Old Court Rd Raw

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Deat Month 3/16/2012 Physician/ 12:25 PM Charles Edward Mullinix Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Carrol1 Carroll Hospice Dove House Westminster If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 8 Date of Birth Social Security Number 7. Age (In vrs. last birthday **Funeral** Months Min (Month, Day, Year) Director 1 🗶 M 2 🗆 F 219-26-1926 MD 9/30/1938 73 Usual Residence of Decede 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ral", or items 23a or 28a-f sho Examiner must be notified at Director 1 Yes 2 X No MD Carrol1 Westminster 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 21157 3815 Baker Rd. 12. Was Decedent Ever in U.S. Armed Forces?

1 🔀 Yes 2 🗆 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 1. Marital Status Black, White, etc. 1 Never Married 2X Married Completed by within 72 hours after Baltimore, Maryland 21215-0036 1 Yes 2 No Specify 3 Widowed 4 Divorced Specify: "natural", White Year or Dates. Unknown event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) is marked other than Elementary/Secondary (0-12) College (1-4 or 5+) 4 Insurance Adjustor State Farm Ins. Co. Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Department of Health and Menta Important: If item 27 is marked any injury or other traumatic evonce. Elizabeth Moore William Mullinix 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 3815 Baker Rd., Westminster, MD 21157 Carol A. Mullinix/Wife 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1XXBurial 2 ☐ Cremation 3 ☐ Removal from State 4 Dopation 5 Other (Specify) Highland View Cem. 3/20/2012 Sykesville, MD Funeral Service 22. Burrier Outern Funeral Home & Crematory, P.A. 1212 W. Old Liberty Rd., Winfield, MD 21784 Inter the disease, or complications that aused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on ach line Interval Between Onset and Death Immediate Cause (Final Ph. sician/ disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Physician/Medical certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE yes, outcome of pregnancy
☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Dav 5 Other (specify) Pregnant at time of death igned by the at be detached for Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 Yes 2 No 3 Probably 4 Unknown been sig Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? After this certificate has funeral director, page 2 2 No Yes 2 N 1 Yes or Attending Physician: 25. Was case referred to medical 26 Place of Death (Check only one) Be Hospital Other: 1 🗌 Yes ဂ္ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at injury 5 \square Pending 1 Natural work? 1 ☐ Yes 2 ☐ No death. M Investigation Accident after deat filled in by the 3 Suicide
4 Homicide Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined

6X1V

within 24 hours a Hospital

> 31. Date filed (Month, Day, Year) State Registrar

Medical

29a. Certifier

29b. Signature and title of certifie

30. Name and address of person who completed cause of death (Item 23a) Type, Print)

Johanna Di Men to 5555 S. Cel nto 32. Registrar's Signature

L Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29d. Date signed (Month, Day, Year

29c. License number

				r Print in Black I				-	
			for State State Registrar	of Maryland / Dep Ce	artment of He rtificate of De		tal Hygieni Reg. N	0010	00025
	Physicia Medic		Decedent's Name (First, Middle, Last) SUSIE E. MOCKABEE			2. E	ate of Death	ay Year	3. Time of Death 7. 05 PM
Z	Examir		4a. Facility Name (if not institution, give street and no		4b. City, Town, or Lo	ocation of Death	41	c. County of Death	
	Funeral Director		5. Social Security Number 404-28-2237 Usual Residence of Decedent	7. Age (In yrs. last birthday) 88 Yrs.		If Under 24 Hrs. 8. D	ate of Birth Month, Day, Year)	324 KY	olace (State or Foreign
	Maryland 28a-f show notified at	Director	Maryland Baltimore	10c. City, Town or Lo	Baltim	nore County		River	10d. Inside City Limits 1 ☐ Yes 2XXNo
	with the	Funeral [10e. Street and Number 101 Day Coach Circle		10f. Zip Code	21220	10g. C	itizen of What Cour USA	ntry?
980	1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	by	11. Marital Status 1	s 2 *_X No Blve	Was Decedent of Hisp If Yes, specify Cuban, 1 ☐ Yes ※XXX No	anic Origin? (Specify Y Mexican, Puerto Rican Specify:	es or No- , etc.)	14. Race - Americ Black, White, Specify: Whit	etc.
Maryland 21215-0036	iin 72 hou e. han "natu e Medical	Completed	15. Decedent's Education (Specify only highest grade complete Elementary/Secondary (0-12) College	ed) (Give	edent's Usual Occupati kind of work done dur DO NOT use retired)		16b. l	Kind of Business/In	dustry
d 21	led within Hygiene. other thai ent, the N	Be C	12 yrs. N/A 17. Father's Name (First, Middle, Last)	Home	emaker	8. Mother's Name (Firs		emaking-0 Sumame)	wn Home
ylan	should be file and Mental h 7 is marked o raumatic eve	오	Roscoe G. Hudson			Nellie M.			
	and 2 shoul Health and I tem 27 is m	- 5	19a. Informant's Name/Relationship (Type, Print) William F. Mockabee (H			d Number or Rural Rou n Circle Ba			
Baltimore,	permit. Page 1 and 3 Department of Healt Important: If item 2 any injury or other		20a. Method of Disposition XX Burial 2 ☐ Cremation 3 ☐ Removal fro 4 ☐ Donation 5 ☐ Other (Specify)	om State 20b. Place of Disprocemetery, cre. Parkwood	matory or other place)	Date 3+23-20	- 1	Location - City or To timore, M	
Balt	permit. Depart Import any inj		21. Signature of Funeral Service Licensee		2. Name and Address 7401 Belair	of Facility Lass C Rd. Balti	ahn Fund More, Mo	eral Home d. 21236	2
~~	Ph _y sician/	S V	23a. Part 1. Enter the disease, or complications that shock, or heart failure. List only one cause on Immediate Cause (Final disease or condition	t caused the eeath. Do not enteach line.		- 99	iratory arrest,		Approximate Interval Between Onset and Death
	Medical Examiner		resulting in death) a. Due t	o (or as a consequence of):		K. I. Sal. Sci. I I.			
ox a	nted d ansit	Examiner	Sequentially list conditions, if any, leading to himterdiate cause. Enter Underlying Cause (Disease or injury that initiated events c.	C (or as a consequence of).					
50 00	e be executed ysician and re burial-transit	lical Ex		o (or as a consequence of):					
. Box 68760	Physician: The law requires that the death certificate be this certificate has been signed by the attending physiciard inector, page 2 should be detached for use as the burns are the burns as the burns are the burns as the burns are t	Physician/Medical	in the past 12 months?		Ectopic pregnancy Other (specify)			23d. Date of delive	ery Day Year
s, P.O.	requires that the been signed by should be detain		Part II. Other significant conditions contributing to	death but not resulting in the	underlying cause given	n in Part I.		use contribute to th	ne cause of death?
of Vital Records,	The law requate has beer page 2 shou	Completed by					24a. Was an autopsy performed?	prior to co death?	osy findings available mpletion of cause of 2 No
ital	sician: The certificate irector, pag	Be	25. Was case referred to medical examiner? 1 \(\subseteq \text{Yes} \) 2 \(\subseteq \text{No} \) Hospital:		Othor	e of Death (Check only			
n of V	ding h. After fune	cate: To	27. Manner of Death 28a. Da	Inpatient 2 ER/Outpatie te of injury onth, Day, Year) 28b. Time o injury	of 28c. Injury a work?	4 Nursing Home 5 t 28d. D	5 ∐ Residence Describe how inju)
Division	Hospital or Attending 24 hours after death. Funeral Director: After stely filled in by the fune	Certificate:	3 Suicide 6 Could not be 28e. Pla	ce of Injury - At home, farm, sti ding, etc. (Specify)	reet, factory, office		ocation (Street ar lity or Town, State	nd Number or Rural e)	Route Number,
_	the Hospital of hin 24 hours a the Funeral D	Medical	29a. Certifier 1 Certifying Physician: To the Check only one) 1 Certifying Nurse Practition	asis of examination and/or inves	stigation, in my opinion,	death occurred at the til	ne, date and place	e, an <mark>d d</mark> ue to the cai	use(s) and manner stated.
	To the within 2 To the comple		29b. Signature and title of certifier		29c. License n			ate signed (Month, I	
	8		30. Name and address of person who completed ca	use of death (Item 23a) (Type,	Print)	200	3	-19 201	2
	Sta		DA SATHISI+ 31. Dan MAR 21 2012 32.	SANNA 90 Registrar's Signature		linsquare	Drive	Baltimo	18, MD 21237
	Registr	ar	TENOR.	7 15. 14 auco					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death MOANEY Physician/ MICHAEL OVETTE X 8.3 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death BALTIMORE NA Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Country) **Funeral** 8. Date of Birth 1**X** M 2 □ F Days Hours Min. 215-58-5036 07-16-52 Director Yrs Usual Residence of Decedent ortant: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County Page 1 and 2 should be filed within 72 hours after death with the Maryland Director 10c. City, Town or Location 10d. Inside City Limits MD NA 1X Yes 2 □ No Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 3033 McElderry Street 21205 USA 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Armed Forces? Black, White, etc. African þ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 No Specify Specify: American Completed 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) permit. Page 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other tha any injury or other traumatic event, the N Avara Beauty School <u>12th</u> Grade Barber Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Richard J. Moanev Cecilia Acree 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Daniel Barryman-Step-son 3033 McElderry Street Baltimore, Maryland 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Denton Veteran Cem. 03-23-12 Hurlock, MD 21. Signature of Funeral Service Licensee Wylie Funeral Home P.A. 22. Name and Address of Facility la ne 638 N. Gilmor Street Baltimore, Maryland 21217 CO. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ ADV MOVED JMV. disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to for as a consequence of Examir Cause (Disease or linjury that initiated events attending physician and for use as the burial-tran resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23b. Was decedent pregnant 3 Ectopic pregnancy 5 Other (specify) 23d. Date of delivery in the past 12 months?
1 Yes 2 No Month Pregnant at time of death Day Year sate has been signed by the a page 2 should be detached for Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed To the Hospital or Attending Physician: The within 24 hours after death.

To the Funeral Director: After this certificate I Yes 2 No 1 Yes funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? ည 1 Yes 2 No Other: 1 A Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 🔀 Natural work? 5 Pending 2 🔲 No the t Accident Investigation Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 29a. Certifier 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. completed Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 = only one) Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) MD039000 E gram 3.18.12

Registrar
DHMH 17 Rev 7/2009

State

BALTIMORE MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Register's Sig

31. Date filed (Month, Day, Year)

2012

MAR 21

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 3 Day 8 Physician/ Charlotte McDermott C. P M 145 Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death **Examiner** 4b. City, Town, or Location of Death Burne Mimore Medical Washington Glen Arundel Anne Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** 9. Birthplace (State or Foreign 1 M 2 XX Days Hours Country) MD NOV 29, 1939 Director **72** 213.36.4967 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director be notified 28a-f 1 Yes 2XX No ANNE ARUNDEL GLEN BURNIE MD 10e. Street and Number ò 10f. Zip Code 10g. Citizen of What Country? ms 23a (must be Funeral 6500 POMPANO DR. 21061 USA 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Armed Forces Black, White, etc. Completed by 1 Never Married 2 Married 2 **XX**No 1 ☐ Yes 2 No Specify: If Yes, Give Specify: WHITE "natural", 3 Divorced Year or Dates. 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) Department of Health and Mental Hygiene. Important: If item 27 is marked other tha any injury or other traumatic event, the Inone. College (1-4 or 5+) HOMEMAKER OWN HOME Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ **GEORGE WENDLING** CHARLOTTE HELWIG 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6500 POMPANO DR. GLEN BURNIE, MD 21061 JOHN MCDERMOTT HUSBAND 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 MBurial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) cemetery, crematory or other place) MEADOWRIDGE CEMETERY 3.22.2012 ELKRIDGE, MD 21. Signature of Funeral Service Licenses FINK FUNERAL HOME, P.A. K. CREKORY FINK M01148 426 CRAIN HWY SW GLEN BURNIE, MD 21061 23a. Part 1. Enter the dise second or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Lung disease or condition CANCER YEAK Medical resulting in death) r as a consequence of): Examiner Sequentially list conditions, Examine cause. Enter Underlying Cause (Disease or iinjury Daw to for as a consecuency of the attending physician and hed for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Completed by Physician/Medical IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Year 1 ☐ Yes ∠∠ 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 X Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24a. Was an Were autopsy findings available prior to completion of cause of autopsy performed? Yes 2 No death? To Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 2 X No 1 Minpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical 1/2 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier

Box 68760 P.O. Records, Division of Vital completed filled in by the funeral director, Hospital or Attending To the Funeral

Baltimore, Maryland 21215-0036

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) VITBERY, MD 301 HOSPITAL DRIVE (ruza) BURNIE MD 20161 31. Date filed (Month, Day egistrar Signat Registrar

29b. Signature and title of certifier

D Vay

MD

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29d. Date signed (Month, Day, Year)

3 18 2012

29c. License number

D 64307

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 08828 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Year Howard . E. Moore 03 2:24 PM 2017 Medical 4a. Facility Name (if not institution, give street and number) 22 South Grows Examiner 4b. City, Town, or Location of Death 4c. County of Death Baltimore University of Maryland Medical Center If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) **Funeral** 16-62-3612 Min. Director 1 **X**M 2 □ F 56 MARV /AND or 28a-f show 10a. State within 72 hours after death with the Maryland Examiner must be notified at 10c. City, Town or Location Director BALTIMORE MD 1 Yes 2 □ No 10e. Street and Number 10g. Citizen of What Country? Funeral or items 23a AISOUITH 4.5,4 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2. Married 1 Yes 2 If Yes, Give Year or Dates Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify "natural", Specify: BLACK Completed 3 Widowed 4 Divorced Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry permit. Page 1 and 2 should be filed within 72 h Department of Health and Mental Hygiene. Important: If item 27 is marked other than "ne any injury or other traumatic event, the Medic once. (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 2 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname မ (UNKNOWN) HOWARD E. MOORE 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21220 80 BENON VNETTE MOORE DAUGHTER BALTIMORE, MARYLAND 20b. Place of Disposition (Name of cemetery, crematory or other place, Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 22. Name and Address of FARE DERRICK C. JONES F/H, PIZIZIS Signature of Funeral Service Licenses MARUIAND 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Appr ximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ Intracerebral disease or condition resulting in death) 48 hours Medical Due to (or as a consequence of): Examiner HYPERTENSION Sequentially list conditions Examiner cause. Enter Underlying Cause (Disease or injury Dua to for as a consequence of: Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last physician and the burial-to Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No 5 Other (specify) Month Pregnant at time of death Day Year 1 ☐ Yes ∠ ☐ 9 ☐ Unknown Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has ral director, page 2 performed? Yes 2 No 2 🗌 No 1 Yes 25. Was case referred to medical æ 26. Place of Death (Check only one) examiner? Hospital Other: 1 ☐ Yes 2 🛛 No ျှ 1 → Inpatient 2 □ ER/Outpatient 3 □ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify, Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 Natural (Month, Day, Year) injury 5 Pending in 24 hours arter con. the Funeral Director; Aff 1 ☐ Yes 2 ☐ No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifie Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title of certifi 29c. License numbe MID. 1619708788 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 22 South Green Street Indrew Walker

DHMH 17 Rev 06-2011

State Registrar Date filed (Month, Day, Year)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink, Ensure All Coppies Are Legible.

oann Mitchell-		1- For State Registrar	of Maryland /		ificate of		u Mentai	F	Reg. No.	0 1	2 0882
Physici ledical Exam		1. Decedent's Name (First, Middle,La Joann Mitchell-	•					Date of Dea Month February	Day Ye	ear	3. Time of Death 0948 hrs
		4a. Facility Name (if not institution, g 6903 Dunmanway Apt. E			1	b. City, Town, or Dundalk	Location of De		4c. County Baltimo		
Funeral Director			Sex 7. Age	(In yrs. las	t birthday) Yrs.	If Under 1 Year Months Days		lin. Aug 6,		I Foreig	thplace (State or unk n untry) Maryland
w any		Usual Residence of Decedent 10a. State 10b. County		-	own or Locati	on	-				10d. Inside City Limits
Aaryland 28a-f show	Director	MD Balti 10e. Street and Number	more	Du	ndalk	10f. Zip Code			10g. Citizen of W	/hat Cour	1 Yes 2 No
vith the M 123a or 2 2 ootiffied		6903 Dunmanway	Apt E	ver in U.S.	13 Wa	21222	panie Origin2 /	Specify Yes or No	USA	a Amori	can Indian, Black,
after death w	by Funeral	1 Never Married 2 Marrie 3 Widowed 4 Divorce	Armed Forces? 1 Yes 2 d If Yas, Giva Year or Dates:	unk N₀	If Ye	es, specify Cuban	, Mexican, Pue		Whi	te, etc. whi	
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland bepartment of Health and Mental Hygiens (manually, or items 23a or 28a-fahe important. If item 77 is marked other than "natural", or items 23a or 28a-fahe injury or other traumatic event, the Medical Francisca must be sofified at oece	Completed I	15. Decedent's Education (Specify of Elementary/Secondary (0-12)	College (1-4 or 5			est of working life.		of work done <u>u.n.l</u> etired)	6 16b. Kind of B	usiness/1	ndustry UNK
ID 21215-0036 should be filled within 7 and Mental Hygiene. 7 is marked other than natic event, the Medica	Be	17. Father's Name (First, Middle, Las			<u> </u>		Mary	me (First, Middle,	hell	,	
MD 2 d 2 shoul lith and M in 27 is m	٦	Brain Canoles S	Rhusband		-900	W. Balt	imore S	Gren Route Nur St; Balti	imore, M	T564 D 21	2 (ip Code) 223
Baltimore, MD permit. Pages I and 2 sh Department of Health and Important: If item 27 is injury or other traumat		20a. Method of Disposition 1 Burial 2 Cremation 3 4 Donation 5 A Other Specific	in state		ematory or oth			Date	20c. Location		Town, State
Balt permit. Depart Import injury		21. Signature of Funeral Service Lice Roma I d S	Waye Dar	ector				ate Anat St; Bal			21201
Physician /Medical xaminer		2 a. Part I. Enter the disease, or comfailure. List only one cause on e Immediate Cause (Final disease or condition resulting in death)	plications that caused t ach line. Alcohol & Due to (or as a consecuence)	Охусс				or respiratory arr	rest, shock, or he	eart	Approximate Interval Between Onset and Death
ed nsit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consec								
50, te be execui ysician and	Medical	X UNPENDED	AMENDED 23a,	27,28	a-f,pe	r me,g92	5 3-23-	-12 sm	_		
Box 68760, c death certificate be executed the attending physician and ed for use as the burial - transi	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 V Unknow	23c. If yes, outcome 1 Live birth 4 Pregnant at ti		2 Feta	al death 3 [er (Specify)	Ectopic preg	nancy	23d. Date of Month		ay Year
P.O. es that th igned by	á	Part II. Other significant conditions	contributing to death	but not resu	ulting in the ur	nderlying cause g	ven i n Part I.		_	_	he cause of death?
cords law requi has been	Completed							24a. Was autop perfo	rmed?		opsy findings available ompletion of cause of 2 No
/ital Re rsician: The ris certificate director, page	Be	25. Was case referred to medical examiner? 1 Yes 2 No	Hospital: 1 Inpatien	t 2 EI	R/Outpatient		of Death (Checonther)	k only one) sing Home 5	Residence 6	✓ Other:	Scene
	tion: To	27. Manner of Death 1 Natural 5 Pending	28a. Date of Injury (Month, Day,Yei	ar)	8b. Time of In	100	y at Work? es 2 🗶 No	28d. Describe	how injury occur	red	
Division pital or Atteodio ours after death.	Certification:	2 Accident Investigat 3 Suicide 6 X Could not determine	be 28e. Place of Inju	ry - At hom			uilding, etc.	28f. Location (S or Town, S Dundalk	state)6903 I	er or Rur)unm a	al Route Number, City
To the Hospital within 24 hours To the Funeral	Medical ((Chican dray	ian: To the best of my r:On the basis of exam and manner stated.								
F & F &	Me	29b. Signature and title of certifier	M)	oth /line Co	20)	29c. License O.C.N			29d. Date sign February 2		
		30. Name and address of person who Parmela E. Southall, MD	•			W. Baltimore	Street, Bal	timore, MD 2	1223		
St	ate	31. Date filed (Month, Day, Year)	32. Pegistrar's	Signature							

DHMH 17 Rev 1/2001 OCME 2006

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item II per spouse g929 7-6-12 vt
State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ 18 D M ake Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Ba OWSON Iting R.R. If Under 1 Year If Under 24 Hrs Months Days Hours Min. 7. Age (In yrs. last birthday) 8. Date of Birth g. Birthplace (State or Foreign **Funeral** (Month, Day, Year) Country) 312-58-432 Director 1 X M 2 □ F 60 WV Usual Re 28a-f show at 10b. County 10c. City, Town or Location 10d. Inside City Limits Completed by Funeral Director notified 1 🗌 Yes 2 🔀 No ms 23a or i 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? and 2 should be filed within 72 hours after death with RNCL USA items 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status and Mental Hygiene. is marked other than "natural", or iter aumatic event, the Medical Examiner. 14. Race - American Indian, Armed Forces? Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify. If Yes, Give Year or Dates Specify: White 3 ☐ Widowed → 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life, DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health at Important: If item 27 is any injury or other trau once. 20b. Place of Disposition (Name of cemetery, crematory or other place, 20a. Method of Disposit Date 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Signature of Funeral Service Licensee 22. Name and Address of Facility uneras 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrespiratory Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician/ disease or condition resulting in death) WONTHS Medical ue to (or as a consequence of) Examine Sequentially list conditions Examiner cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) eral Director: After this certificate has been signed by the attending physician and filled in by the funeral director, page 2 should be detached for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Completed by Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy
4 Pregnant at time of death 5 Other (specify) 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 ☐ Yes 2 ☐ No Month Year Day Yes g Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 1 Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy this certificate has performed? Yes 2 No 2 🗌 No 1 Yes Division of Vital 25. Was case referred to medical To the Hospital or Attending Physician: To Be 26. Place of Death (Check only one) examiner? Hospital 1 🗌 Yes 2 No Other: hospue 1 Inpatient 2 I ER/Outpatient 3 I Other (Specify) 4 Nursing Home 5 Residence 27. Manner of Death Medical Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred within 24 hours after death. To the Funeral Director: After 5 Pending 1 🗌 Yes 2 🗌 No 2 Accident Investigation 3 Suicide 4 Homicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 E Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) AMON CHARLES N 31. Date filed (Month, Day, Year) State MAR 21 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		For	State of	Marylan		artment of H		and M	ental Hy	giene		
		1 - State Registrar			Cer	tificate of D	eath			Reg. No. 2	012	0883
Physicia		Decedent's Name (First, Middle Stella M. Moore	e, Last)						2. Date of De Month March	eath 19,	2012	3. Time of Death 8:50 AM
Medic Examir		4a. Facility Name (if not institution	give street and numb	er)		4b. City, Town, or	Location o	of Death	iniai		unty of Death	0.30 A
and the same of th		Golden Living Cent				Frederick					derick	
Funeral Director		5. Social Security Number		. Age (In yrs. h	-	If Under 1 Year Months Days	If Under a	24 Hrs. Min.	8. Date of Bir (Month, Da	th		place (State or Foreign try)
		Usual Residence of Decedent	1 □ M 2 XXF	97	Yrs.				Jan 12,	1915	Sout	n Carolina
yland f sho ed at	ito	10a. State 10b. County		10c. Cit	y, Town or Loc	ation					1	0d. Inside City Limits
e Mar r 28a- notifie	Sire	Maryland Prince 10e. Street and Number	e George's		Temp1	e Hills						1 Yes 2 XNo
vith th	Funeral Director	5204 Springwood	Drivo			10f. Zip Code	748				of What Coun	itry?
eath v tems er mu	Fune	11. Marital Status	12. Was Decede			Vas Decedent of His	spanic Orig	gin? (Spec	ify Yes or No-		States Race - Americ	an Indian,
36 after d ", or i	þ	1 Never Married 2 Marr	If Van Cina			Yes, specify Cubar		, Puerto F	lican, etc.)		Black, White,	etc.
ours attural	Completed	3 Widowed 4 □ Divorced	Year or Date	s.		Yes 2 No				Spe	AAIT	ite
215 n 72 h an "n Medii	mpl		st grade completed) College (1-4	F.\\	(Give k	ent's Usual Occupa ind of work done du O NOT use retired)		of workin	g	16b. Kind o	of Business/Ind	dustry
21. within yellen the right t, the		12	,	01 5+)	Of	fset Stripp	er			Paint	ting	
Maryland 21215-0036 2 should be filed within 72 hours after death with the Manyland th and Mental Hygiene. 27 is marked other than "natural", or items 23a or 28a-f shortraumatic event, the Medical Examiner must be notified at	To Be	17. Father's Name (First, Middle, L	· ·				18. Mothe	er's Name	(First, Middle,	Maiden Surn	ame)	
laryl should b and Me is mark aumatic	ľ	James Freeman E 19a. Informant's Name/Relationsh	•		I delle Marille	A dd 101			ora Loo			
2 5 ± 5 ± 5		Sandra Delano				g Address <i>(Street ar</i> tarboard Co				-	n, State, Zip C	iode)
		20a. Method of Disposition 1 XXBurial 2 □ Cremation		20b. P	lace of Dispos	sition (Name of atory or other place			ate		on - City or To	wn, State
Baltimore, bermit. Page 1 and Department of Hea Important: If item any injury or other		4 Donation 5 Other (S	pecify)		edar Hil	1 Cemetery	3	3232		Suitla		
Baltimo permit. Page Department of Important: It any injury or		21. Signature of Funeral Service	igenster /	10016	53 22.	Name and Address Ferry Road,	of Facility	Lee :	Funeral MD	Home, Ind	c 6633 O	ld Alexandria
	П	23a. Part 1. Enter the disease, or shock, or heart failure. List o	complications that cau	sed the death						rest,		Approximate
Physician/		Immediate Cause (Final disease or condition	my one cause on each	2	ento							Interval Between Onset and Death
Medical Examiner		resulting in death)	Due to (or	as a consequ	ence of):							
1	ner	Sequentially list conditions, if any leading common at cause. Enter Underlying	b. Due to (br	ав а сопевци	iarios uty:							
rate be executed physician and the burial-transit	Examiner	Cause (Disease or injury that initiated events	c	_								
box 68/60 death certificate be executed death certificate be executed to attending physician and ed for use as the burial-transi	dical E	resulting in death) Last	Due to (or	as a consequ	ience of):							
f 60 icate be	ledic		d									
certific	an/N	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome	me of pregnar		Ectopic pregnancy				23d.	Date of delive	ry
BOX death c the atter hed for u	Physician/Me	in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown		nt at time of d		Other (specify)					Month	Day Year
that the	by Ph	Part II. Other significant condition		h but not resu	ulting in the ur	derlying cause give	n in Part I.		23e. Did to	bacco use co	ontribute to the	e cause of death?
dS, I	ed b	Hypert	ension						1 🗆 🗅	Yes 2 No	o 3 🗆 Prob	ably 4 Unknown
VICAL KECOFICS, ysician: The law requires is certificate has been sig director, page 2 should I	Completed	//							24a. Was a			sy findings available appletion of cause of
The la	Con	MO 10-1-2-1								rmed?	death?	2 PNo
icector	m	25. Was case referred to medical examiner? 1 Yes 2 No	Hospital:			Other	e of Death	n (Check c	nly one)			
OT V	e: 1	27. Manner of Death	28a. Date of	njury 1	ER/Outpatient 28b. Time of	3 DOA 28c. Injury a	4 Nur		e 5 Resid		other (Specify)	
on con con con con con con con con con c	icat	1 Natural 5 Pending 2 Accident Investig	1	Day, Year)	injury	work?	es 2 🗆 N	- 1	id. Describe n	ow injury occi	urieu	
JIVISION OT al or Attending Pl s after death. I Director: After th ed in by the funera	Certificate:	3 ☐ Suicide 6 ☐ Could n 4 ☐ Homicide determine	28e. Place of	Injury - At hor etc. (Specify)	me, farm, stree	et, factory, office		28	3f. Location (S City or Town		nber or Rural I	Route Number,
eral D		29a, Certifier 1 Certifying	Physician: To the best	of my knowle	odgo dooth or	accurred at the time		4				
To the Hospital or Attending Physician: The law requires that the death certifica within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending p completely filled in by the funeral director, page 2 should be detached for use as the completely filled in by the funeral director.	Medical	(Check 2 \square Medical Ex	caminer: On the basis of Nurse Practitioner: To	of examination	and/or investig	ration, in my opinion.	death occ	curred at th	e time date ar	nd place and	due to the caus	se(s) and manner stated
To t Con		29b. Signature and title of certifier	In m			29c. License r	number		1		ned (Month, D	·
	-	30 Name and address of same	the completed	f don't //+-	220) /5: 5:	Roc	5	76:	5/2	3/	20/:	2012
4		30. Name and address of person w	Haque	700	Mor	talaire	AV	€,	rede	2ric	K.M	d. 21701
State Registra	-	31. Date filed <i>(Month, Day, Year)</i> MAR 2 1	2012	tler's Signatu	1 %	a Ked		,		115000	1	
		intil o I	WALL CONTRACT	~~ /	J. 1470	-						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 16^{ay}2012^{Year} MARCH 8:07 P NELSON DERRICK R. Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death PRINCE GEORGE 'S CHEVERLY PRINCE GEORGE'S HOSPITAL Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 **X** M 2 □ F Months Days Hours Min. APRIL 19 75 Yrs JAMAICA Director 577-06-7164 1936 Usual Residence of Decedent 28a-f sho 10a. State 10b. County with the Maryland notified at 10c. City, Town or Location 10d. Inside City Limits Director MD PRINCE GEORGE'S OXON HILL Yes 2 □ No 9 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ral", or items 23a or Examiner must be Funeral 653 AUDREY LANE #102 20745 "natural", or items Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc 1 ☐ Yes 2 🛣 No If Yes, Give þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 BLACK 1 ☐ Yes 2X No Specify: 3 Divorced Completed Year or Dates Medical 16a. Decedent's Usual Occupation Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) permit. Page 1 and 2 should be filed within 7. Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) GOVERNMENT 12TH JANITOR Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ CLARABELL BROWN ROBERT NELSON 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code 653 AUDREY LANE #102 OXON HILL, MARYLAND 20745 DEBORAH NELSON/WIFE 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal from State RESURRECTION CEMETERY 3/31/2012 CLINTON, MARYLAND 4 Donation 5 Other (Specify) 22. Name and Address of Facility J. B. JENKINS FUNERAL HOME, INC. 21. Signature of Funeral Service Licensee 7474 LANDOVER ROAD HYATTSVILLE, MARYLAND 20785 23a. Part 1. Enjer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or leart fail fre. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition Onset and Death Physician/ Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Exami Cause (Disease or iinjury that initiated events resulting in death) Last Physician/Medical Box 68760 as IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 - Fetal death 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Pregnant at time of death 5 Other (specify) Year 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy performed? Yes 2 X N 25. Was case referred≯o medical Be 26. Place of Death (Check only one) examiner? Inpatient 2 🗆 Other: မ ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manuer of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at work?
1 ☐ Yes 2 ☐ No 28b. Time of Certificate: 28d. Describe how injury occurred Natural Accident 5 Pending within 24 hours after death

To the Funeral Director; /
completed filled in by the f Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined

Records, Division of Vital To the Hospital or Attending Physician:

State Registrar

Medical

29a. Certifier

(Check only one)

filed Month, Day, Year,

29b. Signature and title of certifier

who completed cause of death (Item 23a) (Type, Print)

crtifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ obert Menth L Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Raven Community LIVING Baltimore Social Security Number 7. Age (In yrs. last birthday) If Under 8. Date of Birth **Funeral** Birthplace (State or Foreign Country) (Month, Day, Year) 05**-**25**-**26 1 ★ M 2 □ F Months Hours Min. 212-22-1182 Director 85 MD Usual Residence of Decedent "natural", or items 23a or 28a-f show edical Examiner must be notified at filed within 72 hours after death with the Maryland al Hygiene.

Jother than "natural", or items 23a or 28a-f show 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD 1 Yes 2 ☐ No NA Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1763 Homestead Street 21218 USA 12. Was Decedent Ever in U.S. 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Armed Forces? Black, White, etc. African 1 X Never Married 2 A Married δ Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2X No Specify: ^{Specify:} Amer<u>ican</u> Completed 3 Widowed 4 Divorced the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) 12th Grade College (1-4 or 5+) NA Tailor Owner of Cleaners Be permit. Page 1 and 2 should be filed Department of Health and Mental Hy Important: If item 27 is marked othany injury or other traumatic event 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) George Owens Alice 19a. Informant's Name/Relationship (Type, Print) God 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) April C. Pettiford- Daughter Keyworth Avenue Baltimore, Maryland 21215 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Garrison Forest 03-26-12 Owings Mills, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Wylie Funeral Home P.A. 638 N. Gilmor Street Baltimore, Maryland 21217 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Bowel 06st ruction Onset and Death Immediate Cause (Final Physician La aV disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Physician/Medical Examiner Due to (or as a consequence oi): To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Pregnant at time of death Month Day Year Yes 2 No g Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of performed death? 2 🗹 No Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: ၉ 1 🗌 Yes 2 📝 No Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) Certificate: 27. Man xr of Death 28a. Date of injury 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred (Month, Day, Year) 1 🗹 Natural 5 Pending Accident 1 Tes 2 No Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 🗌 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 7/2009

Registrar

Registra s Sign

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 1155 AM PERENE 2012 Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death **Examiner** Baltimora HOSDITAL Randallstown 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Min **Director** 02/03/1933 MARYIAND 28a-f show 10c. City, Town or Location notified at Director BALTIMORE RANDALISTOWN 1 Yes 2 No 10e Street and Number ò 10g. Citizen of What Country? ral", or items 23a or Examiner must be Funeral U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 Yes 2 No If Yes, Give Year or Dates. þ Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Specify: BLACK "natural", 3 Widowed 4 Divorced Completed the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than 'any injury or other traumatic event, the Me onee. Elementary/Secondary (0-12) College (1-4 or 5+) EDUCATION Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) BRITAIN Ellsworth 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21/133 DAUGHTER 3705 SPRINGUELL AVE, RANDALISTOWN, MARYLAND 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State OWNESMITTS, MARYIAND PARRISON FORESTCEME. 03/28/2013 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility E DERRICK C. JONES Elit, P.A. Signature of Funeral Service Licensee HGTS. AUE, BALTIMORE, MARVIAND 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Sep 515 Ph_sician/ disease or condition resulting in death) Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Physician/Medical Examiner as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, To the Hospital or Attending Physician: The law requires 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy certificate has performed? Yes 2 N 2 10 No 1 Yes Division of Vital To Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital Other: 1 Yes 2 KNO 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28c. Injury at work? 1 🔲 Yes 28b. Time of Certificate: 28d. Describe how injury occurred 1 Natural 5 Pending 2 Accident Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completely filled in by 4 Homicide determined within 24 hours after To the Funeral Dire Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
| Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Old Court Road, Randallstown, MD Fafrouni 5401 Abdallah 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 06-2011

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State		State of M	arylan		artment of h		i Mental Hy	/gien	e	1.0	0.07	201
			Registrar 1. Decedent's Name	e (First, Middle, Las	t)		Cer	tificate of l	Jeath	2. Date of D	Reg. N	10.	12	3. Time of D	<u>333</u>
Р	hysicia Medic			Arlene	´	У	Pri	ncipe		Month		ey 20	ear 012	4:00 1	
	Examin		4a. Facility Name (if	not institution, give	street and number)			4b. City, Town, o	r Location of Dea	ath	4	lc. County of			
			Rivervio 5. Social Security No.	ew Nursin		e (In vrs. la	st birthday)	Ess If Under 1 Year	ex If Under 24 Hr	S. 8. Date of Bi	rth			e Co.	Eomion
Di	uneral rector		216-28-6 Usual Residence of	134	□м 2 🔀 F	80	Yrs.	Months Days	Hours Mir		19.	31	Count	yland	Or ergit
land	f show	tor	10a. State	10b. County		10c. City	, Town or Lo	cation					10	Od. Inside City	Limits
e Man	r 28a-i notifie	Direc	MD 10e, Street and Num		imore			Dundal	Lk				\perp	1 🗆 Yes 2	: EXNo
n with the	is 23a oi nust be i	Funeral Director		Aldworth	Road			10f. Zip Code	21222			Citizen of What United			
21215-0036 within 72 hours after deatl giene.	Important; If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	by	11. Marital Status 1 ☐ Never Marri 3ሺ Widowed	ed 2 Married	12. Was Decedent { Armed Forces? 1 ☐ Yes 2 X If Yes, Give Year or Dates.		I	Vas Decedent of H f Yes, specify Cuba ☐ Yes 2 X No	an, Mexican, Pue	Specify Yes or No rto Rican, etc.)		14. Race - Black, Specify:	White, e		
15-(n "nat fedica	Completed		15. Decedent's Ed cify only highest gra	de completed)		(Give i	lent's Usual Occup kind of work done (O NOT use retired)	during most of w	orking	16b.	Kind of Busin	ness Ind	lustry	
212 within	er than	Con	Elementary/Second 10 Yea		College (1-4 or 5	5+)		omemaker				Own H	ome		
Maryland 21215 2 should be filed within 72 th and Mental Hygiene.	rked otheric event,	To Be	17. Father's Name (F	First, Middle, Last) t Jeannet	:ta					_{ame (First, Middle} entina E		_			
Mary d 2 should alth and N	n 27 is ma er trauma		19a. Informant's Na Mrs. Deb		rpe, Print) ne11 (Daugh	ter)	19b. Mailir 241	g Address (Street 5 Stoneyl	and Number or F	Rural Route Numb	er, City o	or Town, State n, Mar	e, Zip C y lar	ode) 210	47
Baltimore, Department of Hea	ant: If iten ury or oth				Removal from State	CE	emetery, cren	sition (Name of natory or other place of Jesi		Date 3/22/2012	1	Location - Ci	-	wn, State aryland	1
Balti permit. Departr	Importa any inju once.		21. Signature of Fur	neral Service Licens	ee		22	Name and Addre Duda-Ruci 7922 Wise	ss of Facility K Funera	1 Home o	of D	undalk	, Ir	nc.	
M	sician/ edical iminer	er	shock, or hear Immediate Cause (I disease or condition resulting in death)	t failue. List only or Final n	a. Due to (or as	a consequ	Do not ente					typ	e	Approximate Interval Betwe Onset and De	
60 % Ite be executed	physician and the burial-transit	edical Examiner	cause. Enter Under Cause (Disease or that initiated events resulting in death) L	linjury	c. Due to (or as										
ox 68	ttending or use as	ΣΙ	IF FEMALE: 23b. Was decedent in the past 12 r 1 ☐ Yes 2 ☐ 9 ☐ Unknown	nonths?	23c. If yes, outcome 1 ☐ Live Birth 4 ☐ Pregnant a 9 ☐ Unknown	2 Fetal	death 3	Ectopic pregnanc Other (specify)	гу		Į.	23d. Date o		ry Day Yea	ar
ds, P.O.	in signed by the a uld be detached f		Part II. Other signifi	icant conditions	ontributing to death b	ut not resu	ılting in the u	nderlying cause giv	ven in Part I.				_	e cause of deat	
of Vital Records, ig Physician: The law requires	certificate has been s irector, page 2 should	Completed by								24a. Was auto perf 1 Yes	psy ormed?	prio dea	r to con th?	sy findings ava	
tal ician:	sertific ector,	Be	25. Was case referre examiner?		Hospital:				ace of Death (Ch	eck only one)					
of Vi	this ald	는 일	1 ☐ Yes 2 2 27. Manner eath	I No	1 Inpati	ry	ER/Outpatien 28b. Time of	t 3 DOA Othe	4 Nursing	Home 5 Resi			Specify)		
on C anding	ir. Afte	ficat	1 Natural 2 Accident	5 Pending Investigation		r, Year)	injury	work	? Yes 2 ☐ No	Esq. Bossings		, oooaa			
Division tal or Attendings after death.	al Directo	l Certificate:	3 ∐ Suicide 4 ☐ Homicide	6 Could not be determined	28e. Place of Injubuilding, etc	ry - At hor c. (Specify)	me, farm, stre	et, factory, office		28f. Location (City or To			r Rural i	Route Number,	
he Hospit in 24 hour	To the Funeral Director: After completed filled in by the funer	Medical	(Check 2	Medical Examination	ician: To the best of ner: On the basis of e e Practioner: To the	xamination	and/or invest	igation, in my opinio	on, death occurred	d at the time, date	and plac	e, and due to	the cau	se(s) and manne	er stated
To t	roon Con		29b. Signature and t	itle of certifier	(Di	>		29c. License	number 355	93	29d. D	ate signed (M	10nth, D	ay, Year)	
	3		30. Name and addre	ess of purson who c	ompleted cause of d	1 . 1	23a) (Type, P	24 Me	ace Au	e, Bai	KG,	MD	21	122,	
	Stat legistra	e	31. Date filed (Mont)	NAR 2 1 2	32. PONG	r's Signati	ire	. 4.1							
	Rev 7/20			HAL C I C	IICI CENT	4	a. g								

Division of Vital Records, P.O. Box 68760 🞘

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Wilma Jean Pillion State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Reg. No Registrar 1. Decedent's Name (First, Middle,Last) 2. Date of Death Physician/ Medical Examiner 1129 hrs March 16, 2012 Wilma Jean Pillion 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 416 Meadowood Drive Edgewood Harford 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or **Funeral** oreign Min. Months Days Hours Director 215-68-5545 2 X F 11/24/1954 Country) Maryland 1 M 57 Yrs Usual Residence of Decedent 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Yes 2 X No Harford Edgewood Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 靣 416 Meadowood Drive 21040 11. Mantal Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No 14. Race - American Indian, Black, Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married White, etc. Yes f Yes, Give Yaar White 3 Widowed 4 X Divorced 1 Yes 2 No specify: Specify: Hygiene. d other than "natural", ğ 16a. Decedent's Usual Occupation (Give kind of work done 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) the Medical Baltimore, MD 21215-0036 Certified Nurse's Assistant Healthcare 12 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Lest) Lloyd E. Pillion Lucy D. Turner 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 i Zerelda Spencer / Sister 2330 Orsburn Lane, Joppa, MD 21085 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State crematory or other place) Ħ 3/20/2012 Chesapeake Crematory Beltsville, MD 4 Donation 5 Other Specify: 22. Name and Address of Facility 21. Signature of Funeral Service Licenses Dorota Marshall Maryland Cremation Services, PO Box 1413 Baltimore, MD 21203 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Mixed drug (Metoprolo1, Amitriptyline, Temazapam) Approximate Interval **Physician** Between Onset and /Medical Death Immediate Cause (Final disease aIntoxication Examiner or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, Examiner Due to for as a consequence of if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last The law requires that the death certificate be executed signed by the attending physician and be detached for use as the bunal - tran Physician/Medical \square AMENDED 23a,27,28a-f, per me,g925 3-23-12 sm X UNPENDED Division of Vital Records, P.O. Box 68760, IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the Live birth 2 Fetal death 3 Ectopic pregnancy Dev Year past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 V Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ≦ 1 Yes 2 No 3 Probably 4 Unknown Completed certificate has been a rector, page 2 should 24a, Was an 24b. Were autopsy findings available prior to completion of cause of autopsy performed death? Yes 2 No 1 Yes 2 No fo the Hospital or Attending Physician; 25. Was case referred to medical 26. Place of Death (Check only one) å Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other Nursing Home 5 Residence 6 🗹 Other: Scene this 1 Yes 2 No 27. Manner of Death 28b. Time of Injury After 28a. Date of Injury (Month, Day, Year 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural Ingested prescription 1 Yes 2 X No 5 Pending death. fd 11:29 am fd 3-16-12 medications 2 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc 28f. Location (Street and Number or Rural Route Number, City 3 X Suicide hours after 6 Could not be or Town, State) 416 Meadowood Dr. Edgewood, MD. determined within 24 hours a 4 Homicide Residence Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29d. Date signed (Month, Day, Year) 29b. Signature end title of certifie 29c. License number O.C.M.E March 17, 2012 Dau 30. Name and address of person who completed cause of death (Item 23a) Deve Carol Allan, MD Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

Registrar

MAR 21

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend 8 per State of Maryland / Department of Health and Mental Hygiene amend 8 per ab. g926 4/16/12 kh Certificate of Death Reg. No. For State Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 0-3 evol Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner Battomorei university of Maryland Medical Baltimore If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | 15/12 | Months | Days | Hours | Min. (Month, Days | 17/12 | 17/12 | 17/12 | 17/12 | 17/12 | 17/12 | 17/12 | 17/12 | 17/12 | 17/12 | 17/12 | 17/12 | 17/12 | 17/12 | 17/12 | 17/12 | 17/12 | 17/12 | 17/12 | 17/12 | 17/12 | 17/12 | 17/12 | 17/12 | 17/12 | 17/12 | 17/12 | 17/12 | 17/12 | 17/12 | 17/12 | 17/12 | 17/12 | 17/12 | 17/12 | 17/12 | 17/12 | 17/12 | 17/12 | 17/12 | 17/12 | 17/12 | 17/12 | 17/12 | 17/12 | 17/12 | 17/12 | 17/12 | 17/12 | 17/12 | 17/12 | 17/12 | 17/12 | 17/12 | 17/12 | 17/12 | 17/12 | 17/12 | 17/12 | 17/12 | 17/12 | 17/12 | 17/12 | 17/12 | 17/12 | 17/12 | 17/12 | 17/12 | 17/12 | 17/12 | 17/12 | 17/12 | 17/12 | 17/12 | 17/12 | 17/12 | 17/12 | 17/12 | 17/12 | 17/12 | 17/12 | 17/12 | 17/12 | 17/12 | 17/12 | 17/12 | 17/12 | 17/12 | 17/12 | 17/12 | 17/12 | 17/12 | 17/12 | 17/12 | 17/12 | 17/12 | 17/12 | 17/12 | 17/12 | 17/12 | 17/12 | 17/12 | 17/12 | 17/12 | 17/12 | 17/12 | 17/12 | 17/12 | 17/12 | 17/12 | 17/12 | 17/12 | 17/12 | 17/12 | 17/12 | 17/12 | 17/12 | 17/12 | 17/12 | 17/12 | 17/12 | 17/12 | 17/12 | 17/12 | 17/12 | 17/12 | 17/12 | 17/12 | 17/12 | 17/12 | 17/12 | 17/12 | 17/12 | 17/12 | 17/12 | 17/12 | 17/12 | 17/12 | 17/12 | 17/12 | 17/12 | 17/12 | 17/12 | 17/12 | 17/12 | 17/12 | 17/12 | 17/12 | 17/12 | 17/12 | 17/12 | 17/12 | 17/12 | 17/12 | 17/12 | 17/12 | 17/12 | 17/12 | 17/12 | 17/12 | 17/12 | 17/12 | 17/12 | 17/12 | 17/12 | 17/12 | 17/12 | 17/12 | 17/12 | 17/12 | 17/12 | 17/12 | 17/12 | 17/12 | 17/12 | 17/12 | 17/12 | 17/12 | 17/12 | 17/12 | 17/12 | 17/12 | 17/12 | 17/12 | 17/12 | 17/12 | 17/12 | 17/12 | 17/12 | 17/12 | 17/12 | 17/12 | 17/12 | 17/12 | 17/12 | 17/12 | 17/12 | 17/12 | 17/12 | 17/12 | 17/12 | 17/12 | 17/12 | 17/12 | 17/12 | 17/12 | 17/12 | 17/12 | 17/12 | 17/12 | 17/12 | 17/12 | 17/12 | 17/12 | 17/12 | 17/12 | 17/12 | 17/12 | 17/12 | 17/12 | 17/12 | 17/12 | 17/12 | 17/12 | 17/12 | 17/12 | 17/12 | 17/12 | 17/12 | 17/12 | 17/12 | 17/12 | 17/12 | 17/12 | 17/12 | 17/12 | 17/12 | 17/12 | 17/12 | 17/12 | 17/12 | 17/12 | 17 Social Security Number 6 Sex Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 M 2 D F INFANT Director Usual Residence of Decedent show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f shot any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 😾 Yes 2 🗌 No MD Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 3755 Ravenwood Ave 21213 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 11. Marital Status 14. Race - American Indian Armed Forces?
1 ☐ Yes 2 X No Black, White, etc. 1 X Never Married 2 Married Completed by Yes Maryland 21215-0036 1 ☐ Yes 2 【☐ No Specify: Black If Yes, Give Specify: 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) INFANT INFANT INFANT INFANT Be 17. Father's Name (First, Middle, Last) unk 18. Mother's Name (First, Middle, Maiden Surname) ೭ Brittany Green 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Brittany Green - mother 3755 Ravenwood Ave; Baltimore, MD 21213 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) 4 Donation 5 Other (Specify) in state 22. Name and Address of Facility State Anatomy Board Funeral Service 655 W. Baltimore St; Baltimore, MD 21201 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examine Due to (or as a consequence of) Hospital or Attending Physician; The law requires that the death certificate be executed signed by the attending physician and defacthed for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Year 5 Other (specify) Day Pregnant at time of death should be detached 9 Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown 1 Yes peen s 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has performed this certificate 2 1 No Yes 2 No 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital 2 No 1 🗌 Yes Other: Certificate: To 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) To the Funeral Director: After thi completed filled in by the funeral 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred (Month, Day, Year) Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined

within 24 hours a To the Funeral L

State Registrar

Medical

29a. Certifier

29b. Signature and title of certifier

DHMH 17 Rev 7/2009

pleted cause of death (Item 23a) (Type, Print)

1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29d. Date signed (Month, Day, Year)

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

outh Greene street Baltimore

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #18 Per ANA BD G3/21/2012 JH. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1 Decedent's Name (First Middle Last) 2. Date of Death Month 03 Physician/ Day Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** University Of Meryland medical MO Battimore Baltimore If Under 1 Year If Under 24 Hrs. 8. Date of Birth 5. Social Security Number **Funeral** (Month, Day, 1 □ M 2 🗹 F Director INFANT Usual Residence of Decedent 23a or 28a-f show 10a. State 10b. County 10c. City, Town or Location event, the Medical Examiner must be notified at Directo Baltimore MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 21213 3755 Ravenwood Ave. pernit. Page 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items: Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-11. Marital Status 14. Race - American Indian. Armed Forces2 1 Yes 2 No If Yes, specify Cuban, Mexican, Puerto Rican, etc. Black, White, etc. þ 1 XNever Married 2 Married Baltimore, Maryland 21215-0036 Specify: Black If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: Completed 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) INFANT Elementary/Seconday (0-12) INFANT INFANT INFANT Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Brittany Green - mother 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Brittany Green - mother 3755 Ravenwood Ave; Baltimore, MD 21213 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1

Burial 2

Cremation 3

Removal from State 4 Donation 5 Other (Specify) in state Signature of Ronald S. 22. Name and Address of Facility State Anatomy Board 655 W. Baltimore St; Baltimore, MD 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest or heart failure. List only one cause on each line. Immediate Cause (Final xtreme Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Pregnant at time of death 5 Other (specify) 1 Yes 2 2 9 Unknown been signed by the should be detached g Unknown P.O. Part II. <mark>Other significant conditions</mark> contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 perform Yes 2 within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, Division of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 Tes ပ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manper of Death Certificate: 28a. Date of injury 28c. Injury at work? 28b. Time of 28d. Describe how injury occurred Natural (Month, Day, Year) 5 Pending 1 🗌 Yes 2 No Accident
Suicide Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, dearn occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the P within 2. 29b. Signature and title of certifier

3. Time of Death

9. Birthplace (State or Foreign

21201

Approximate Interval Between Onset and Death

Year

Day

2 No

1 🗌 Yes

10d. Inside City Limits

1X Yes 2 ☐ No

ZO1Z

0023 M

State Registrar

Christina 31. Date filed (Month, Day, Year)

DHMH 17 Rev 7/2009

Greene Street Baltimore MD 2120

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

22.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND ITEM#10e perFH G925, 3/21/2012 WS
State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death Month 1. Decedent's Name (First, Middle, Last) 3. Time of Death Physician/ Laverne Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Hospita Samaritan Balt MOTE Social Security Number If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 214-38-0658 1 M 2 F Hours Min 70 **Director** 091 MARUAND 28a-f shov 10a. State 10b. County 10c. City, Town or Location the Medical Examiner must be notified at 10d. Inside City Limits **Funeral Director** BALTIMORE 1 Yes 2 No MD10e. Street and Number Harford ö 10g. Citizen of What Country? 21214 items 23a ROAD 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. $\{\mathcal{A}_{\mathcal{O}\!V_j}, \bigcap \}$ Baltimore, Maryland 21215-0036 ģ 1 Never Married 2 Married Yes 2 No If Yes, Give Year or Dates. 1 Yes 2 No Specify "natural", 3 Widowed 4 Divorced BLACK Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Department of Health and Mential Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Me once. Elementary/Seconday (0-12) College (1-4 or 5+) MANUFACTOR PARTS INSPECTOR Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) GERTRUDE မ Ro JAMES 19a. Informant's Name/Relations op (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5528 SilvE DAUGHTER HERMEEN MYRICK RD., BALTIMORE, MARY IAND
Date 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 26/2012 BALTIMORE, MARYLAND 4 ☐ Donation 5 ☐ Other (Specify) DERRICK C. SONES FIH, P.A. Signature of Funeral Service Incensee PARK HGTS. AVE., BALTIMORE MARYIAND 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician! arrhy thmia disease or condition resulting in death) Medical Due to (or as a co. sequence of): Examiner Sequentially list conditions, Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): signed by the attending physician and detached for use as the burial-transit that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months? Pregnant at time of death 1 Yes 2 L 2 No Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown should peen ascular accidents . Were autopsy findings available prior to completion of cause of 24a. Was an To the Funeral Director: After this certificate has completed filled in by the funeral director, page 2 s autopsy death? the Hospital or Attending Physician: The I hin 24 hours after death. 1 Yes 2 19 No Yes 2 No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital 1 ☐ Yes 2 ☑ No မ 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 PER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 Natural iniury work?
1 ☐ Yes 2 ☐ No 5 Pending Accident Investigation 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined 24 hours a Funeral C Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated within 2 29b. Signature and title of certifier 29d, Date signed (Month, Dav. Year) D0062689 March 18, 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) FEET MD SKOLLOCH POVEN Blvd Balt Md 21239 3hx 31. Date filed (Month, Day State MAR 2 1 2012 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Physician/ March 21 2012ª Riley 1:39 A M Alice Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Baltimore NA 2309 Chelsea Terrace Social Security Number 9. Birthplace (State or Foreign Country) MD If Under 1 Year | If Under 24 Hrs. . Age (In yrs. last birthday) 8. Date of Birth **Funeral** 1 🗆 M 2 🛛 F Months Days Director 220-20-4909 84 Usual Residence of Decedent sho 10a. State 10c. City. Town or Location 10d. Inside City Limits notified at Director 28a-f XX Yes 2 No MD NA Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ral", or items 23a or Examiner must be Funeral USA 21216 2309 Chelsea Terrace 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 🎛 No 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. African þ 1 XNever Married 2 Married Page 1 and 2 should be filed within 72 hours after Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 No Specify. Completed 3 Divorced 4 Divorced American Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Il Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Department of Health and Mental Hygiene. Important: If item 27 is marked other tha any injury or other traumatic event, the I ŇÁ unk. Company Nurses Assistant Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) unk. unk. ည 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 201 E. Baltimore Street 15th Floor Baltimore, MD. Artie Shaw-Guardian 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State 03-22-12 Lansdowne, MD 4 Donation 5 Other (Specify) Mt. Zion Cem. 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Wylie Funeral Home P.A. Gilmor Street Baltimore, Marvland 21217 38_N. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition resulting in death) Onset and Death Ph_sician/ Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine sician and burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): ng physician a Physician/Medical Division of Vital Records, P.O. Box 68760 attending IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death nse 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months? 4 ☐ Pregnant at time of death 9 ☐ Unknown signed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 W Unknown page 2 should need 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has autopsy performe 1 Yes 2 No Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Be 1 Yes 2 No မ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death To the Hospital or Attending Pt within 24 hours after death.

To the Funeral Director: After it completed filled in by the funeral 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred work? 1 Natural injury 5 Pending Accident
Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of 3-21-12 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Keisters 6821

State Registrar Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death 2012 Physician/ MMonth 10:30PM Anna E. Raab Medical Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death County of Death **Examiner** Glen Burnie Arne Arundel BAILIMORE WAShinsten Medical Center Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** 217-01-3548 Director 1 🗆 M 2 🔀 🕏 94 7-14-1917 NY Usual Residence of Decedent item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1

Yes 2 □ No MD Baltimore Dundalk 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 2510 Liberty Parkway 21222 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc þ 1 Never Married 2 Married ☐ Yes 2 🔀 No Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 No Specify Specify: White Completed 3 XWidowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Mill Worker Bethlehem Steel Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 John Zubalik Stefana Zubalik Pavucek 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Patricia Blimline-Daughter 514 Grandin Ave., Severna Park, MD 21146 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 1 $\!X\!$ Burial 2 $\!\square$ Cremation 3 $\!\square$ Removal from State 3-21-2012 Dundalk, MD 4 ☐ Donation 5 ☐ Other (Specify) Sacred Heart Of 22. Name an Jesus acility Bradley-Ashton Funeral Home PA, 2134 Willow Spring Road, 21222 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Interval Between Onset and Death Immediate Cause (Final GI Blecdin Ph_ysician/ disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** eng1 FAILUSE Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence on To the Hospital or Attending Physician: The law requires that the death certificate be executed physician and s the burial-trans that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 attending pl IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Pregnant at time of death 1 Yes 2 g 2 No 9 Unknown signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ò Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an certificate has autonsy death? 1 ☐ Yes 2 ☐ No __ Yes eral Director: After this certific filled in by the funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital 1 Yes 2 No Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) မ 27. Manner of Death 1 Natural Date of injury (Month, Day, Year) 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28b. Time of Certificate: 28d. Describe how injury occurred injury 5 Pending 2 Accident Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) 24 hours a Medical 29a. Certifier 👺 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check within 2 To the I 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certific 00274

Registrar
DHMH 17 Rev 06-2011

BAltimore Waihirston Medical Center

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ANC()

31. Date filed (Month, Day, Year)

GM

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Date of Death 3. Time of Death Physician/ SE OSE Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner BALTIMORE SEASONS HOSPICE @ NORTHWEST HOSPITAL RANDALLSTOWN 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** (Month, Day, Year) Days Hours Min 1 □ M 2 🗓 F **Director** 212-14-9923 97 09/01/1914 MD Usual Residence of Decedent show 10d. Inside City Limits with the Maryland 10a. State 10b. County 10c. City, Town or Location Director notified 28a-f 1 Yes 2 X No BALTIMORE OWINGS MILLS MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? must be r Funeral USA 21117 4730 ATRIUM COURT, #478 be filed within 72 hours after death 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Armed Forces?

1 Yes 2 X No "natural", or il dical Examine Black, White, etc. þ 1 Never Married 2 Married 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates Specify: 3 X Widowed 4 ☐ Divorced Completed WHITE 15. Decedent's Education (Specify only highest grade completed) Decedent's Usual Occupation
(Give kind of work done during most of working 16b. Kind of Business/Industry life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) OWN HOME HOMEMAKER other Be Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) and Mental F is marked o ပ FRIEDLAND REBECCA BRATMAN t. Page 1 and 2 should be tment of Health and Men rtant: If item 27 is mark traumatic LOUIS 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) SLADE AVENUE, #116, PIKESVILLE, MD 21208 Department of Health Important: If item 27 any injury or other the MERRY COPLIN / DAUGHTER Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 X Burial 2 Cremation 3 Removal from State cemetery, crematory or other place BETH EL MEMORIAL PARK 03/16/2012 4 ☐ Donation 5 ☐ Other (Specify) RANDALLSTOWN, MD 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 21208 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) **Examiner** Sequentially list conditions if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical or Attending Physician: The law requires that the death certificate be P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy
Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No 5 Other (specify) Month Day Year Pregnant at time of death 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à Division of Vital Records, 2 No 3 Probably 4 Unknown 1 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an performe 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 ပု 1 Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner eath 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 2 atural 5 Pending work?
1 Yes 2 No Accident Investigation **Director:** Suicide Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined

within 24 hours a

Hospital

State Registrar

Medical

29a, Certifier

(Check only one) 29b. Signature and title

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registra Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 3 2012 7:25 P М Cecelia Theresa Storms Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore Timonium <u>Stella Maris Hospice</u> If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days Hours Director 199-38-2787 1 □ M 2X F 06/05/1947 64 Pennsylvania Usual Residence of Decede 23a or 28a-f show ist be notified at 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits the Maryland Director 1 Yes 2 No Baldwin Baltimore MD 10f. Zip Code 10g. Citizen of What Country? Funeral death with Examiner must 21013 U.S.A. 13601 Brookline Road 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. "natural", or þ 1 Never Married 2 XMarried 1 ☐ Yes 2 X No If Yes, Give within 72 hours after Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify: 3 Divorced 4 Divorced White Completed Year or Dates permit. Page 1 and 2 should be filed within 72 hour Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical gores. 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Library of Congress 12 Librarian Assistant Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Joseph Moyer Rosenberger, Jr. Cecelia Sparks 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 13601 Brookline Road - Baldwin, Maryland 21013 <u>Stephen E. Storms (husband)</u> 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State ÇEm. cemetery, crematory or other place 1 X Burial 2 Cremation 3 Removal from State 03/26/2012 4 Donation 5 Other (Specify) St. John the Evan. Ch. Hydes, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility E. F. Lassahn Funeral Home, G A. 11750 Belair Road - Kingsville, Maryland 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Ph, i i n disease or condition resulting in death) CEREBROVASCULAR ACCIDENT Medical Due to (or as a consequence of **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine Due to (or as a consequence of): or Attending Physician: The law requires that the death certificate be executed burial-trar that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 the attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 X No Month Day Year isigned by the at Id be detached for 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? STORMS þ 1 Yes 2 No 3 Probably 4 Unknown Completed should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s has CECELIA autopsy performed 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) 1 Yes 2 X No မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 🗶 Other (Specify) HOSPICE funeral Certificate: 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) 1 X Natural 5 Pending s after death.

I Director: Af
ed in by the fu 1 Yes 2 🗌 No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined within 24 hours a Medical 29a Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 X Certifying Nurse Fractitioner: To the best charge lowledge ad at the time idate and plane, and due to the 29b. Signature and title 29c. License number 29d. Date signed (Month, Day, Year,

Pr o 1511 ur DHMH 17 Rev 06-2011 TRACIE L.

2300 DULANEY VALLEY RD.

TIMONIUM, MD 21093

of person who completed cause of death (Item 23a) (Type, Print)

CRNP

MORGAN

12-02134 John Sturgis

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 1. For State Certificate of Death Registrar

1. Decedent's Name (First, Middle,Last) 2. Date of Death Physician/ Month Day March 14, 2012 Medical Examiner 1445 hrs John Sturgis 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 100 Greenway, Apt 224 Perryville Cecil 5. Social Security Number If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or **Funeral** 7. Age (In vrs. last birthday) Hours Months Days Min Director Feb 9, 1946 countryNew York 125-34-8861 1X M 2 F 66 Yrs Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No Cecil Perryville Pages I and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or items 23a or 28a-f sho rother tranmatic event, the Medical Examiner must be notified at once. Director 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 21903 100 Green Way; Apt 224 USA Funeral 11 Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married Armed Forces? White, etc. 1 X Yes Specify: white If Yes, Give Year or Dates: 3 X Widowed 4 Divorced 1 Yes 2X No specify: 2 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry unk Completed during most of working life. DO NOT use retired) unk Elementary/Secondary (0-12) College (1-4 or 5+) 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) John Conlon Sturgis Frances Buckley 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 900 W. Baltimore St; Baltimore, MD 21223 O.C.M.E. 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State Date Baltimore, crematory or other place) Burial 2 Cremation 3 Removal from State 4 Donation 5 Other Specify: in 22. Name and Address of Facility State Anatomy Board Ronald . Baltimore St; Baltimore, art I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval **Physician** Between Onset and /Medical Death a. Hypertensive Atherosclerotic Cardiovascular Disease Immediate Cause (Final disease **E**xaminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions. if any, leading to immediate Due to (or as a consequence of): Examine cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and transit The law requires that the death certificate be executed Physician/Medical e attending physician for use as the burial -UNPENDED AMENDED Division of Vital Records, P.O. Box 68760, IF FEMALE: 23c. If ves. outcome of pregnancy 23d. Date of delivery 3b. Was decedent pregnant in the Fetal death 1 Live birth 3 Ectopic pregnancy Day Year past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown 9 Unknown ı signed by the a d be detached fo Part ii. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? á 1 Yes 2 No 3 Probably 4 Unknown Colon Cancer Completed certificate has been s ector, page 2 should 24a Was an 24b. Were autopsy findings available prior to completion of cause of autopsy performed' page Yes 2 🗸 No 2 No Hospital or Attending Physician: 25. Was case referred to medical 26.Place of Death (Check only one) funeral director, Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other Nursing Home 5 Residence 6 Other: Scene this 1 Yes After 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of Injury 8c. Injury at Work? 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 1 V Natural 5 Pending 1 Yes 2 No Accident 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City 3 Could not be Suicide or Town, State) determined Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Sa 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) O.C.M.E. March 15, 2012 30. Name and address of person who completed cause of death (Item 23a) Aesistant Medical Examiner Russell Alexander MD. 900 W. Baltimore Street, Baltimore, MD 21223 31. Date filed (Month, Day, Year) egistrar's Signatu State Registrar **OCME**

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 23pt. II per doc g925 3-23-12 vt
State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death March 18, 2012 Physician/ Theodor Frank Schmidt 4:10PM Medical 4a. Facility Name (If not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 4102 Taylor Avenue Baltimore Apt. 305 Baltimore 5. Social Security Number 8. Date of Birth (Month, Day, August 5. 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** 1 🖾 M 2 🗆 F Months Days Hours 218-30-6183 Director 85 Poland Usual Residence of Decedent f show ral", or items 23a or 28a-f shore Examiner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director Maryland Baltimore Baltimore 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 4102 Taylor Avenue Apt 305 21236 U.S.A. 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. ģ 1 Never Married 2 X Married White 1 Yes 2 X No Specify: "natural", 3 Divorced 4 Divorced Completed d Mental Hygiene. marked other than "natur. matic event, the Medical I 15. Decedent's Education (Specify only highest grade completed) Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) Lab Technician Brick Making Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Department of Health and Menta Important: If item 27 is marked any injury or other traumation ൧ Aleksy Schmidt Rumel von Czarnowska 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6 Charlesbrooke Rd. Elizabeth Sheridan - Niece Baltimore, MD 21212 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State Sacred Heart Jesus March 21,2012 Baltimore, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Baltimore, Maryland 21214 Paul L. Hartson <u>Leonard J.</u> Ruck. 5305 Harford Rd. Inc. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Onset and Death Immediate Cause (Final Ph_sician/ disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** IN EARCT MYOCAR Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examin CONCRESTIVE Cause (Disease or iinjury that initiated events and Due to (or as a consequence of) resulting in death) Last burialphysician Physician/Medical the as attending IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? for Pregnant at time of death the detached g Unknown g Unknown signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ρ CHRONIC OBSTRUGIVE Pulmonno DISENSE 2 No 3 Probably 4 Unknown Completed Were autopsy findings available prior to completion of cause of death? Asbestosis 24a. Was an has page 2 autopsy this certificate 1 Yes 2 No Yes within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: Other: ည 1 Inpatient 2 Inpatient 3 Inpatient 2 Inpatient 3 Inpatient 2 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 2 Inpatient 3 Inpatient 2 Inpatient 3 Inpatient 3 Inpatient 2 Inpatient 3 Inpa 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: work?
1 \sum Yes 2 \sum No Natural iniury 5 Pending Accident
Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical Grifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier

Division of Vital Records, P.O. Box 68760 To the Hospital or Attending Physician:

Baltimore, Maryland 21215-0036

0

State Registrar 31. Date filed (Month Day, Year)

29b. Signature and title of certifier

(Check

only one)



30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

29d. Date signed (Month, Day, Y

M72123

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death Physician/ Virginia Strausser Month March L. 2012 9:50 P M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Baltimore Co. 10 Horney Court Essex 5. Social Security Number 8. Date of Birth 9. Birthplace (S (Month, Day, Year) Country) June 11, 1930 Eary Land Funeral 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Months Days Hours 1 □ M 2 🔽 F Director 81 215-28-2294 Usual Residence of Decedent 23a or 28a-f show ist be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 🗌 Yes 2 😾 No Maryland Baltimore Essex 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? Funeral and 2 should be filed within 72 hours after death with Health and Mental Hygiene.
tem 27 is marked other than "natural", or items 23s, the reaumatic event, the Medical Examiner must), the reaumatic event, the Medical Examiner must). 21221 United States 10 Horney Ct. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11 Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 2 No
If Yes, Give Black, White, etc. ò 1 Never Married 2 Married Maryland 21215-0036 1 Yes 2 No Specify: Completed 3 X Widowed 4 Divorced White Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) Insurance 12th N/A Manager Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Charles Kruse Isabel Webb 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 10 Horney Ct. Essex, Maryland permit. Page 1 and 2 Department of Health Important: If item 2 any injury or other t Joseph Kruse (Nephew) 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Hilltop Service Corp 3/19/2012 Towson, Maryland 21. Signature of Juneral Service Lice 22. Name and Address of Facility Duda-Ruck Funeral Home of Dundalk, 7922 Wise Ave. Dunalk, Maryland 21 1 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of) use as the burial-transi that initiated events resulting in death) Last Due to (or as a consequence of) attending physician for use as the burial Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery ☐ Ectopic pregnancy in the past 12 months?

1 Yes 2 No Pregnant at time of death 5 Other (specify) Month Day Year signed by the at d be detached for 4 ☐ Pregnant 9 ☐ Unknown 1 Yes 2 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an page 2 autopsy performed death? certificate 1 ☐ Yes 2 ☐ No Yes or Attending Physician: 25. Was case referred to medical director. Be 26. Place of Death (Check only one) Other: 4 Nursing Home 1 Tes 2 No Certificate: To 1 Inpatient 2 ER/Outpatient 3 DOA 5 Residence 6 Other (Specify) this completed filled in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at 28h Time of 28d. Describe how injury occurred 1 Natural 5 Pending work 1 Yes 2 No 2 Accident
3 Suicide Investigation 6 Could not be after deat 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined To the Hospital within 24 hours a To the Funeral I Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 🗆 Certifying Nurse Practioner. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certif 29d. Date signed (Month, Day, Year)

Box 68760 P.O. Records, Division of Vital

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

AL: 5 ANA 1, MD 6736 (100 HOLHBIKO AUE BALL MO 21222 6736 31. Date filed (Month, Day, Year) State Registrar **ORIGINAL**

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Day 201 ^{Year} William Sams Edward March 2:52 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City. Town, or Location of Death 4c. County of Death Baltimore Co. Genesis Heritage Nursing Home Dundalk If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Social Security Number 6. Sex Age (In vrs. last birthday 8. Date of Birth **Funeral** (Month, Day, Months Hours Country) Maryland 1X M 2 D F Min **Director** Oct. 213-32-0106 Usual Residence of Decedent or 28a-f shov notified at 10a. State 10b. County 10c. City. Town or Location within 72 hours after death with the Maryland 10d. Inside City Limits Director MD Baltimore Dunda1k 1 Yes 2 Xio 10e. Street and Number 10f. Zip Code ö 10g. Citizen of What Country? er than "natural", or items 23a or the Medical Examiner must be Funeral 7912 Charlesmont Road 21222 United States 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11 Marital Status 14. Race - American Indian, Armed Forces? Black, White, etc. 1 Never Married 2X Married by Baltimore, Maryland 21215-0036 1 Yes 2 XNo Specify: If Yes, Give Year or Dates 3 Widowed 4 Divorced Specify: Completed White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Baltimore City Elementary/Seconday (0-12) College (1-4 or 5+) Page 1 and 2 should be filed within ment of Health and Mental Hygiene. ant: If item 27 is marked other that ury or other traumatic event, the Merce of the traumatic event the Merce of the traumatic event the Merce of the traumatic event the European event ev Sanitation Crew Leader 8 Years Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Blanche P. Feldman William L. Sams 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7912 Charlesmont Road Dundalk, MD 21222 19a. Informant's Name/Relationship (Type, Print) Carolyn J. Sams (Wife) permit. Page 1 and 2 Department of Health Important: If item 27 any injury or other tr 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 🖾 Burial 2 🗌 Cremation 3 🔲 Removal from State cemetery, crematory or other place) Gardens of Faith Cem. 3/19/2012 Baltimore, Maryland 4 Donation 5 Other (Specify) Si aturi Funeral Solice 22. Name and Address of Facility al Home of Dundalk, Inc. 7922 Wise Ave. Dundalk, Maryland 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician a Atherosclerotic Cardiovascular Disease disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Gastrointestinal Bleed Sequentially list conditions Examine any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to for as a consequence of Physician: The law requires that the death certificate be executed Malnutrition and use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): physician Physician/Medical Division of Vital Records, P.O. Box 68760 Dementia attending IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Por 4 Pregnant a Month Dav Yea Pregnant at time of death 2 No the a detached 9 Unknown þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. completed filled in by the funeral director, page 2 should be det 23e. Did tobacco use contribute to the cause of death? Completed by Parkinsons Disease, Urinary Retention, Urinary Tract 1 🗆 Yes 2 🗆 No 3 🗆 Probably 4 ី Unknown 24b. Were autopsy findings available prior to completion of cause of death? Infection Recurrent 24a. Was an autopsy yeriormed? Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 4X Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b Time of 28c. Injury at 28d. Describe how injury occurred Hospital or Attending 1 🕅 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No death. Accident Investigation 24 hours after deat Funeral Director: Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time date and place. 29a. Certifier (Check within 2. the 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one

State Registrar 29b. Signature and title of certifier

31. Date filed (Month, Day, Year)
MAR 2 1 2012

nder

1 Julka

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Savinder K. Julka, M.D. 2 Market Place

29c. License number

D27188

Dundalk, Maryland

29d. Date signed (Month, Day, Year)

21222

19/2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Certificate of Death Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Edwin P^{M} Shepherd Larry March 201 5:41 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 29 Winding Woods Way Pasadena Anne Arundel 5. Social Security Number . Age (In yrs. last birthday) 9. Birthplace (State or Foreign If Under 1 Year If Under 24 Hrs. 8. Date of Birth **Funeral** 1 € M 2 □ F Months Days Hours 03-15-1941 West Virginia Director 70 236-64-1112 Usual Residence of Decedent or 28a-f show notified at 10a State 10b. County 10c. City. Town or Location the Maryland 10d. Inside City Limits Director 1 Yes 2 X No Anne Arundel Maryland Pasadena 10e. Street and Number ö 10f. Zip Code 10g. Citizen of What Country? ns 23a r r must b pe Funeral within 72 hours after death with 21122 29 Winding Woods Way United States items ? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian "natural", or ite Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates. Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify. White Specify Completed 3 Widowed 4 Divorced the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Page 1 and 2 should be filed within 72 nent of Health and Mental Hygiene. ant: If item 27 is marked other than ' Elementary/Seconday (0-12) College (1-4 or 5+) Terminal Manager Transportation Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Merle Shepherd Evelyn Campbell traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Peggy A. Shepherd (Wife) Winding Woods Way Pasadena, Md. item 2 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date T i 1 🖵 Burial 2 🗌 Cremation 3 🔲 Removal from State permit. Page Department of Important: If any injury or 4 ☐ Donation 5 ☐ Other (Specify) Hill Memorial Pk 03-12-201 Middle River, Maryland Signature of Funeral Service Licensee 22. Name and Address of Facility Duda-Ruck Funeral Home of Dundalk, 7922 Wise Hyenue Dundalk, Maryland 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Physician/Medical Examiner Due to (or as a consequence of) Cause (Disease or iinjury that initiated events resulting in death) Last • Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death.
• Z4 hours after death.
• Funeral Director. After this certificate has been signed by the attending physician and eled filled in by the funeral director, page 2 should be detached for use as the bunial-transi Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Pregnant at time of death 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Wiknown 24b. Were autopsy findings available prior to completion of cause of 24a, Was an autopsy performed? 1 Yes 2 No 1 Yes 2 No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital Other: |요 1 Yes 2 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) Manner of Deat 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred injury Natural 5 Pending 1 Yes 2 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Centifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29h. Signature and 29c. License number ne and addre on who completed cause of death (Item 23a) (Type

State

Registrar

DHMH 17 Rev 7/2009

0

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Manyland / Department of Health and Mental Hydiene

		•	1 - For State of N Registrar	laryland / Depa <i>Cer</i>	artment of F tificate of E			Reg. No.	2 08849	
	Physicia		1. Decedent's Name (First, Middle, Last) Donald Hug	o Sekira, Sr.			2. Date of Dea Month Ma	th a r 16 ay 2012 Year	3. Time of Death 10:15 A M	
)	Medic Examin		4a. Facility Name (if not institution, give street and number) 2520 Kensington Gardens A	pt 407	4b. City, Town, or	Location of Death Ellicott City		4c. County of De	ath Ioward	
T	Funeral Director		5. Social Security Number 6. Sex 7. A 1 M 2 F	ge (In yrs. last birthday) 83 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day Dec 2	9. B	irthplace (State or Foreign ountry)	
	yland if show ed at	ctor	Usual Residence of Decedent 10a. State 10b. County Howard	10c. City, Town or Loc	cation	Ellicott City			10d. Inside City Limits 1 ☐ Yes 2 ☐ No	
	th the Mar 3a or 28a be notifi	al Director	10e. Street and Number 2520 Kensington Gardens Apt 407		10f. Zip Code	21043		10g. Citizen of What Country? U.S.A.		
036	ould be filed within 72 hours after death with the Maryland d Mental Hygiene. marked other than "natural", or items 23a or 28a-f show marke other than "natural" and items 23a or 28a-f show marke other, the Medical Examiner must be notified at	ed by Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced 12. Was Decedent Armed Forces 1 New Person 2 1 Yes, Give Year or Dates,	Ever in U.S. 13, V	Nas Decedent of Hi f Yes, specify Cuba	spanic Origin? (Spec n, Mexican, Puerto R Specify:	ify Yes or No- ican, etc.)	14. Race - An Black, Wh Specify:		
21215-0036	within 72 hour giene. Ier than "natu t, the Medical	Completed by	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 4	(Give I	Decedent's Usual Occupation (Give kind of work done during most of workir. life. DO NOT use retired) Financial Planner				s/Industry II Lynch	
land 2	uld be filed v Mental Hyg narked othe natic event,	To Be	17. Father's Name (First, Middle, Last) Hugo Charles	Sekira		18. Mother's Name	(First, Middle, I Hele r	Maiden Surname) 1 Theresa Kol a	ıs	
Maryland	Je s B		19a. Informant's Name/Relationship (Type, Print) David Sekira Son	19b. Mailir 4 Gr	ng Address (Street a rainfield Ct. C	and Number or Rural Catonsville, M	Route Number, D 21228	City or Town, State, 2	Zip Code)	
Baltimore,	Page 1 and 2 s ment of Health s ant: If item 27 i ury or other tra		20a. Method of Disposition 1	20b. Place of Dispo cemetery, cren Atlantic	sition (Name of natory or other plac Crematory , LL	C Mar 2	ate 26, 2012	20c. Location - City of Glen E	or Town, State Burnie, MD	
Balt	permit. Page Department of Important: If any injury or once.		21. Signature of Funeral Service Library	h + Moleys	Name and Address Slack Fu 3871 Old	îneral Home, P. I Columbia Pike	A. Ellicott C	ity, MD 21043		
	Physician/ Medical Examiner	- E	23a. Part 1. Soler the disease, or complications that caus shock, or heart failure. Ust only one cause on each li Immediate Cause (Final disease or condition resulting in death) Due to (or as	ache death. Do not entene.				est,	Approximate Interval Between Onset and Death	
	ted	Examiner	cause. Enter Underlying Cause (Disease or injury	B CoriSaylanica cij.						
260	cate be executed physician and s the burial-transit	edical Ex	that initiated events resulting in death) Last C. Due to (or as d	s a consequence of):						
Box 68	Physician: The law requires that the death certificate be executed this certificate has been signed by the attending physician and rail director, page 2 should be detached for use as the burial-transi			2 Fetal death 3 at time of death 5	Ectopic pregnand Other (specify)	y		23d. Date of o	delivery Day Year	
s, P.O.	ires that the signed by the details and the details and the details and the details are the signess and the signess and the signess are the signess and the signess are the signess and the signess are the si	þ	Part II. Other significant conditions contributing to death			en in Part I.			to the cause of death? Probably 4 Unknown	
Records,	i cian: The law require certificate has been si rector, page 2 should I	Completed					24a. Was a autop perfor 1 Yes	sy prior to med? death	autopsy findings available occumpletion of cause of ? es 2 ANO	
of Vital	ysician: is certific director,	To Be	25. Was case referred to medical examiner? 1 Yes 2 No Hospital: 1 Inpa	tient 2 ER/Outpatier	Oth	ace of Death (Check on the character) 4 Nursing Home		ence 6 Other (Sp	ecify)	
on of	ling The After fune	Certificate:	27. Manner of Death 1 Natural 5 Pending 2 Accident Investigation	jury 28b. Time of injury	work	y at ? Yes 2 \(\sum \) No	8d. Describe h	ow injury occurred		
Division	al or Attences after death			ijury - At home, farm, str tc. (Specify)	eet, factory, office	2	8f. Location (S City or Town	treet and Number or F n, State)	Rural Route Number,	
_	To the Hospital or A within 24 hours after To the Funeral Dire completely filled in the funeral bire to the funeral Direction of the funeral bire to the funeral bire to the funeral bire to the funeral bire full full bire full	Medical	29a. Certifier (Check only one) 1 Certifying Physician: To the best only one) 1 Medical Examiner: On the basis of the ba	examination and/or inves	tigation, in my opinio	on, death occurred at t	the time, date ar	nd place, and due to th	e cause(s) and manner stated.	
	Vith vith com		29b. Signature and title of certifier		29c. License	25947		29d. Date signed (Mo	nth, Day, Year)	
Ö			30. Name and address of person who completed cause of	death (Item 23a) (Type, F	Print)		٠ - ١٠	re- I pour L	, ~	
	Sta	te	31. Date filed (Month, Day, Year) 32. Regis	tras Signature	Ry, CH	MEKSVILIE	- 63	300	29	
	Registr	ar	MAR 2 1 2012 General	a. 19						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State of Mar				/lental Hygi	ene	10	00050	
		_	Registrar 1. Decedent's Name (First, Middle, Last)	Cer	tificate of D	Death		g. No. 4 U	16	08850	
П	Physicia		Maurice Lee Sisk				2. Date of Death Month	Day	Year	3. Time of Death 9:10A M	
	Medio Examin		4a. Facility Name (if not institution, give street and number)		4b. City, Town, or	Location of Death	March	1 20 2012 9:10A 4c. County of Death			
-)		785 Hess Ct.			minster		Carroll			
	Funeral			n yrs. last birthday)	If Under 1 Year Months Days	8. Date of Birth					
Н	Director		214-26-8373 1XI M 2 □ F Usual Residence of Decedent	82 _{Yrs.}		Hours Min.	8-28-1		MD	<i>y)</i>	
	and show	lor	10a. State 10b. County 10	Oc. City, Town or Loc	ation				10	d. Inside City Limits	
	Mary 28a-f otifie	irec	MD Talbot		East	on				1 ☐ Yes 2 No	
State 10a. State 10b. County 10c. City, Town or Location 10c. City, City or Location 10c. City or Location 10c. City or Location 10c. City or Location 10c. City or Locati								10g. Citizen of What Country?			
	ath wi	nuel	9285 Honeysuckle Dr. 11. Marital Status 12. Was Decedent Ever		21601		USA	SA			
ဖွ	ter de or ite	by F	1 ☐ Never Married 2 ☐ Married Armed Forces?	lf lf	Vas Decedent of His Yes, specify Cubar		Rican, etc.)		e - America k, White, e		
21215-0036	urs af tural", al Exa	ted	3 ☐ Widowed 4 【★Divorced If Yes, Give Year or Dates.	1	Yes 2X No	Specify:		Specify:	whit	te	
15-	72 ho n "nat ledica	Completed	15. Decedent's Education (Specify only highest grade completed)	(Give k	ent's Usual Occupa ind of work done do		ing 1	6b. Kind of Bu	siness/Ind	ustry	
212	vithin jiene. er tha		Elementary/Secondary (0-12) College (1-4 or 5+)	I	o NOT use retired) e Opera:	tor		Consti	ruct i	ion	
b	filed val Hyg al Hyg d othe	Be	17. Father's Name (First, Middle, Last)				e (First, Middle, Ma			2011	
ylaı	should be filed within 7 n and Mental Hygiene. 7 is marked other than raumatic event, the Me	မ	Benjamin F. Sisk			Mary T	riplett				
Maryland	2 shouth and the and the straim traum		19a. Informant's Name/Relationship (Type, Print)	I	g Address (Street a					ode)	
	and Healt Healt tem 2		Wayne F. Cavey-nephew 20a. Method of Disposition	785 20b. Place of Dispos	Hess Ct						
Baltimore,	permit. Page 1 Department of Important: If it any injury or one		1 ☐ Burial 2 🕱 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	cemetery, crem	atory or other place)		0c. Location -	-		
a ļ	permit. F Departm Importa any inju		21. Signature 1, uneral Service Licensee	South C	Name and Address	s of Facility Fl	etcher	ykesvi	rite,	MD	
<u> </u>	8 8 E 8	(1)	Momas V. Jukhi	1-12	54 E. Ma	ain St.	.Westmi	nster.	MD 2	21157	
			23a. Part 1. Enter the disease, or complications that caused the shock, or heart failure. List only one cause an each line.	e death. Do not enter	r the mode of dying	, such as cardiac o	r respiratory arrest	1		Approximate Interval Between	
~~.	Pnysician/ Medical	1	Immediate Cause (Final disease or condition resulting in death)	12 U	Mu	Oylu	eus l	euk	eus	Onset and Death	
1	Examiner		bue to (or as a co	onsequence of):	J						
		Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	onsequence of):							
	cuted and transi	xam	that initiated events c.								
	certificate be executed nding physician and use as the burial-transit	dicalE	resulting in death) Last Due to (or as a co	onsequence of):							
760	icate t g phys	0	d								
89 ×	ending r use a	an/N	IF FEMALE: 23c. If yes, outcome of p	oregnancy Fetal death 3	Ectopic prognancy			23d. Date	e of deliver	y	
Box	requires that the death certific been signed by the attending I should be detached for use as	by Physician/M	in the past 12 months? 1 Yes 2 No 9 Unknown 1 Live Birth 2 Live Birt	ne of death 5	Other (specify)			Mor	nth C	Day Year	
P. O.	that the ned by the detach	F.	Part II. Other significant conditions contributing to death but n	not resulting in the un	iderlying cause give	en in Part I.	23e Did toba	cco use contri	hute to the	cause of death?	
	uires the signer of signer	g b								ibly 4 🗆 Unknown	
Vital Records,	law requires las been sigi	Completed					24a. Was an			y findings available	
Rec	sician: The law i certificate has t lirector, page 2 s	E O					autopsy performe	d2 d	eath?	pletion of cause of	
ta Ta	cian: ertifica ector,		25. Was case referred to medical examiner?		26. Plac	ce of Death (Check		1101	LI Tes Z		
₹	this alo	욘	1 Ves 2 No Hospital: 1 Inpatient 27. Manny of Death 28a. Date of injury	2 ER/Outpatient		4				NETHEW'S	
0 0	tending Physician: leath. tor: After this certific the funeral director,	cate	1 Natural 5 Pending 2 Accident Investigation		28c. Injury : work? M 1 🔲 Y		28d. Describe how	injury occurred	d (ZESI YENG	
Division of	Atter er dea ector by th	Certificate:	3 ☐ Suicide 6 ☐ Could not be 28e. Place of Injury -	At home, farm, stree			28f. Location (Stree	et and Number	r o <i>r Rur</i> al R	oute Number,	
2	the Hospital or Attending Physician: hin 24 hours after death. the Funeral Director. After this certifican appletely filled in by the funeral director,		building, etc. (S)				City or Town, S				
	Hosp 24 ho Fune etely f	Medical	29a. Certifier (Check 2 Medcel Examiner: On the basis of exam	ination and/or investig	ation, in my opinion	 death occurred at 	the time, date and r	place and due	to the caus	e(s) and manner stated	
	To the Hospital or Attending I within 24 hours after death. To the Funeral Director: After completely filled in by the funer		only one) 3 Certifing Nurse Practitione: To the be	st of my knowledge, o	29c. License r	e time, date and pla number	ce, and due to the o	ause(s) and ma	anner as sta	ited.	
			· Mohima ku	WIS MY	D.	52 35	1X B	- 20	0 -	12	
レ			30. Name and address of person who completed cause of death	(Item 23a) (Type, Pri	int)	-11	1 1			0 51155	
1	, Cros		31. Date filed (Month, Day, Year) 32. Registrar's S	Douth	Center	2+. K	rsthu	stu	, m	1031124	
4	State Registra	-	MAR 2 1 2012 Sema	B. park							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death , Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 03 Physician/ Samuel F. Steinberg 2012 9:15 A Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 9701 Parkland Road Parkville Baltimore 5. Social Security Number 6. Sex X 1 \(\text{M} \) 2 \(\text{F} \) 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** Days Min. MO2/P3/1940 Hours Waryland 214-38-7187 72 Director 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location death with the Maryland Director r 28a-f sh notified 1 Yes 2 □ No MD Baltimore Parkville 10e. Street and Number ō 10f. Zip Code 10g. Citizen of What Country? ms 23a or must be r Funeral 9701 Parkland Road 21234 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 14. Race - American Indian. Examiner Armed Forces? Black, White, etc. o. þ 1 Never Married 2 Married 2 No ARMY Baltimore, Maryland 21215-0036 within 72 hours after 1 ☐ Yes 2 No Specify: If Yes, Give Year or Dates. Specify: "natural", 3 Widowed 4 Divorced 1963-65 White Completed of Health and Mental Hygiene.
item 27 is marked other than "natur
other traumatic event, the Medical I 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Sheer Operator Metal Be filed v 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ . Page 1 and 2 should be ment of Health and Menta Elizabeth Wilkens Samuel Steinberg 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Susan Carol Steinberg / Wife 9701 Parkland Road, Parkville, MD 21234 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Page 1 a
Department of H
Important: If ite
any injury or otl 3/19/2012 Chesapeake Crematory Beltsville, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Dorota Marshall Maryland Cremation Services, PO Box 1413 Baltimore, MD 21203 mode of dying, such as cardiac or respiratory arrest, 23a. Part 1. Enter the diseas complications that caused the death. Do not enter shock, or heart failure. List only one cause on each line Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to for as a consequence of: or Attending Physician: The law requires that the death certificate be executed as the burial-transi Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): physiciar Physician/Medical Division of Vital Records, P.O. Box 68760 attending IF FEMALE: use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy 3 🗌 in the past 12 months?
1 ☐ Yes 2 ☐ No ģ Pregnant at time of death the Unknown 9 Unknown þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page perform 1 Yes 2 No Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital 2 1 No Other: 1 🗌 Yes မ 1 Inpatient 2 ER/Outpatient 3 DOA 5 🗹 Residence 4 Nursing Home 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 1 ☐ Yes 2 ☐ No 27. Manner of Death 28b. Time of Certificate: 28d. Describe how injury occurred I Director: After the funeral 1 Natural injury 5 Pending death Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, filled in by determined thin 24 hours a the Funeral D Hospital Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 To the F only one) 29d. Date signed (Month, Day, Year) 29b, Signature and title of certifier License number 3.16.2012 00023322

State

E think

Sachcler & MD

SAGIA

31. Date filed (Month, Day

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

126 A

32. Registry's Signature

for State Registrar Certificate of Death Reg. No. 🤈 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician/ REED W. SMITH, SR. 03 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Anne Arundel Medical Center Annapolis 5. Social Security Number 215-24-3082 If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Rirth 6. Şex **Funeral** Months Days (MPO72671928 1**X** M 2 □ F 83 Director 28a-f show 10b. County "natural", or items 23a or 28a-f sho dical Examiner must be notified at 10a State 10c. City, Town or Location Director MD Anne Arundel Annapolis 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 336 Dubois Road 21401 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S 14. Race - American Indian, Armed Forces?

Yes 2 NArmy Black, White, etc. 1 Never Married Married þ Maryland 21215-0036 1 ☐ Yes Ž☐ No Specify: If Yes, Give Year or Dates 3 Widowed 4 Divorced Specify. Completed the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) than Elementary/Secondary (0-12) College (1-4 or 5+) Electrician and Mental Hygie is marked other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Samuel R. Smith Cecelia Tauser and 2 should b Health and Mea 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If item 27 is any injury or other trait Anna H. Smith / Wife 336 Dubois Road, Annapolis, MD 21401 Baltimore, 20a. Method of Disposition
1 ☐ Burial 2 Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Chesapeake Crematory 3/21/2012 4 Donation 5 Other (Specify) Beltsville, MD Signature of Funeral Service Licensee 22. Name and Address of Facility le Dorota Marshall Maryland Cremation Services, PO Box 1413Baltimore, MD 21203 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician/ ASPIRATION PNEUMONIA disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) that the death certificate be executed Due to (or as a consequence of) resulting in death) Last Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month signed by the at d be detached for 9 Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, METASTATIC MELANOMA 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an autopsy performed?

Yes 2 No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica Division of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) 1 ☐ Yes 2 ♠No Other: မ 1 XInpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) Injury at work? Certificate: 28b. Time of 28c. 28d. Describe how injury occurred Natural 5 Pending 2 No 2 Accident
3 Suicide
4 Homicide Investigation Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical **Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 5 per th g930 8-2-12 vt
State of Maryland / Department of Health and Mental Hygiene

2012

Anne Arundel

USA

Electrical

White

9:13

9. Birthplace (State or Foreign County)

10d. Inside City Limits

Interval Between Onset and Death

1400KS

Were autopsy findings available prior to completion of cause of

death? 1 ☐ Yes 2 🔭 No

MO 2/401

1 Yes 2 No

AM

BYV

State Registrar Inothy

31. Date filed (Month, Day, Year)

M.

DHMH 17 Rev 06-2011

2001 Medical Parlowar

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MD

32. Registrar's Signature

Cas stack

	•	or Print in I					_	ible.
	For State Registrar	te of Marylan		irtment of F tificate of L		, 0	ene g. No. 2 ()	12 0885
	Decedent's Name (First, Middle, Last)	<u></u>				T -		3. Time of Death
ician/ edical		HELEN	COLEN	E STINE		2. Date of Death) Day 20	12:45 A
miner	4a. Facility Name (if not institution, give street ar	nd number)			Location of Death		4c. County	
ral	Locust Lodge 5. Social Security Number 6. Sex	7. Age (In yrs. la	ast birthday)	Pasade If Under 1 Year	na If Under 24 Hrs.	8. Date of Birth	Anne	Arundel 9. Birthplace (State or Foreig
tor	237 26 2117 1 DM 22		Yrs.	Months Days	Hours Min.	(Month, Day, 1		Country)
	Usual Residence of Decedent 10a. State 10b. County		y, Town or Loc	ation		12 10 -	1920	North Carol 10d. Inside City Limits
ecto	MD Anne Arund		saden					1 🗆 Yes 2 🔀 N
Funeral Director	10e. Street and Number			10f. Zip Code		10	g. Citizen of W	Vhat Country?
uneral	7801 East Shore R				21122		U.S	.A.
by Fu	Arm	s Decedent Ever in U.S led Forces? Yes 2 🔀 No	S. 13. W	as Decedent of Hi Yes, specify Cuba	spanic Origin? (Sp n, Mexican, Puerto	ecify Yes or No- Rican, etc.)		e - American Indian, k, White, etc.
ed by Fu	if Ye	es, Give r or Dates.	1	☐ Yes 2 X No	Specify:		Specify:	White
To Be Completed I	15. Decedent's Education (Specify only highest grade comp	pleted)	(Give k	ent's Usual Occup	ation Juring most of work	kina	6b. Kind of Bu	usiness/Industry
S m		ege (1-4 or 5+)	Ìife. DC	NOT use retired)			El amas	ntawa Cabaa
Be (17. Father's Name (First, Middle, Last)		Cus	todian 	18. Mother's Nam	ne (First, Middle, Ma		ntary School
욘	Ot	is Pope			Maude	Unkno	wn	
	19a. Informant's Name/Relationship (Type, Print)	19b. Mailin	g Address (Street a	and Number or Rui	al Route Number, (City or Town, St	tate, Zip Code)
	Renee Bell - Daugh		-	E. Sho	re Rd	<u>Pasaden</u>		21122
	1 Burial 2. Cremation 3 Remova	I from State C	emetery, crem	sition (Name of atory or other place				City or Town, State
once.	4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee	lBay			ory 103/1			ore, MD al Home, PA
once	1/2//		1	69 Rivi	era Dri	ve Pas	runera adena	. MD 21122
	23a. Part 1. Enter the disease, or complications shock, or heart failure. List only one cause	on each line.			,			Approximate Interval Between
ın/	Immediate Cause (Final disease or condition	iterio Sili	notic	Cordi	o Vascu	las Dis	ease	Onset and Death
cal ner	resulting in death)	ue to (or as a consequence of the land)	ence of):					
ner	Sequentially list conditions, if any, leading to immediate D	ue to (or as a consequ	ience of):					
Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	De mentro	i e					
I —	resulting in death) Last D	ue to (or as a consequ	ience of):					
edic	d							
Physician/Medical	23b. Was decedent pregnant	es, outcome of pregna		Estacio eraceno			23d. Date	e of delivery
sicis	1 Ves 2 No	Pregnant at time of d		Other (specify)	у		Mor	nth Day Year
Phy	9 LI ORKHOWII		ulting in the ur	nderlying cause oiv	en in Part I	23a Did tobs	acco use contri	ibute to the cause of death?
Completed by	Part II. Other significant conditions contribution Claudic of Huch's	of Dula	ionary	Disco	re			3 Probably 4 🗷 Unknov
ete						24a. Was an		Vere autopsy findings available
dwo						autopsy	ed? d	prior to completion of cause of leath? ☐ Yes 2 🏋 No
Be C	25. Was case referred to medical examiner?			26. Pla	ace of Death (Chec	1 Yes 2	LÆ NO I	Li fes 2 Lif No
은	1 Yes 2 No	1 Inpatient 2 I			4 ☐ Nursing H			er (Specify) 185T. Livin
Certificate:	1 X Natural 5 ☐ Pending	Date of injury (Month, Day, Year)	28b. Time of injury	28c. Injury work M 1 🗆		28d. Describe how	injury occurre	ed
i i i i i	2 Accident Investigation 3 Suicide 6 Could not be 4 Homicide determined	Place of Injury - At ho						er or Rural Route Number,
	a storming	building, etc. (Specify,)			City or Town,	State)	
Medical	29a. Certifier 1 Certifying Physician: To (Check 2 Medical Examiner: On the control of the contr	the best of my knowledge the basis of examination	edge, death o and/or investi	ccurred at the time	e, date and place, a	and due to the caus	e(s) and manne place, and due	er as stated. to the cause(s) and manner sta
Me	only one) S Gertifying Nurse Practi	tioner: To the best of n	ny knowledge,	death occurred at t	ne time, date and pl	ace, and due to the	cause(s) and m	nanner as stated.
	1/ Km 1	us.		042	820	29	03/	Month, Day, Year)
	30. Name and address of person who completed	d cause of death (Item	23a) (Type, Pi	rint)				- 7 - 7 - 7 - 7
	/Christopher a	leBoni	370	8 mou	tain K	ed Pas	desse	MB. 2112.
State	31. Date filed (Morlal, Day, Year)	32. Registrar's Signat	ure					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death Physician/ Month Edwa av10 201 Medical acility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Date of Birth 9. Birthplace (State or Foreign **Funeral** (Month, Day, Year, Months Hours Min Country) 1 **Y**M 2 □ F **Director** show 10c. City, Town or Location permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f shor any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10d Inside City Limits Director 1 Yes 2 No TIMOre 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 12. 14. Race - American Indian ed Forces? Yes 2 No Black White etc. 1 Never Married 2 Married þ Yes Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ► No If Yes, Give Year or Dates Specify 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Ons bore Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Wa 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number of Rural Route Number, City or Town, State, Zip Code) Da lor-Williams 20b. Place of Disposition (Name of cemetery, crematory or other place)

Bayriew Cremator 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 21. Signatur Funeral Service Licensee ame and Address of ral Homes MD 21216 23a. Part T. Enter the disease, of complications that gaused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Retween Onset and Death Immediate Cause (Final colo-rectal concer Physician/ ASTOTA disease or condition resulting in death) Medical Due to (or as a consequence of Examiner Sequentially list conditions, it any, each of the rectangle of the rectangle cause. Enter Underlying Cause (Disease or injury Examine Date to for each prinary uning off the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) physician Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Records, P.O. Box 68760 for use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☐ No Day Year Pregnant at time of death signed by the at 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? certificate has 2 No 1 Yes Division of Vital funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital 2 🗹 No Other: 1 Yes ျှ 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home this 28a. Date of injury (Month, Day, Year) 27. Manner of Death Time of 28b. 28c. Injury at Certificate: 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director: After completely filled in by the funer work?
1 Yes 2 No 1 Natural 5 Pending injury Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner. To the pest of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29d. Date signed (Month, Day, Year)
MArch 17, 2012 29b. Signature 29c. License number cons

Registrar

DHMH 17 Rev 06-2011

State

and address of person who compl

N. Charles St. Balto. Md 2120x

d cause of death (tem 23a) (Type, Print)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

nend #5 Per FH G926 4/02/2012 JH
State of Maryland / Department of Health and Mental Hygiene 1 - State Registrat Certificate of Death Reg. No. . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Day 2012 Year 20, Donaline Taylor March 4:00 P. M Louise Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Baltimore Gilchrist Towson 1 Year | If Under 24 Hrs. Davs | Hours | Min. 52Speial Security Number 216-30-7877 8. Date of Birth (Month, Day, Year) If Under 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Months Director 1 □ M 2 🛛 F Yrs June 27, 1934 Maryland 77 Usual Residence of Deceden or 28a-f show 10a. State 10b. County aţ 10c. City, Town or Location 10d. Inside City Limits Director notified 1 Yes 2 X No Marvland Baltimore Parkville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? be . 23a r Funeral filed within 72 hours after death with Examiner must 8820 Walther Blvd. Apt. 2314 21234 U.S.A. items 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces?
1 ☐ Yes 2 X No Black, White, etc. þ 'natural", or 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Specify: White 3 ☐ Widowed 4X Divorced Completed Year or Dates int than "he." "he Medical F 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) 12 years College (1-4 or 5+) Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Nonce. Department of Defense Analyst Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Page 1 and 2 should be f ment of Health and Menta Joseph Taylor Dorothy Grimes 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) (daughter) 210 E. Melrose Ave. Baltimore, Maryland 21212 <u>Jennifer Ciattei</u> 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State Green Mount Crematory 3-23-12 4 ☐ Donation 5 ☐ Other (Specify) Baltimore, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Mitchell-Wiedefeld Funeral Home, Inc. 6500 York Road Baltimore, Maryland 23a. Part 1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician Due to (or as consequence of): disease or condition resulting in death) Medical Examiner onvicianons Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to for as a consequence of 2025 Peripin vasular burial-trar that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical the Hospital or Attending Physician: The law requires that the death certificate be 本名が打石がものの 系 Division of Vital Records, P.O. Box 68760 the IF FEMALE: nse 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? page 2 should be detached for Day Year 9 Unknown 9 Unknown ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Chronic myclopenso les kenja Chronic OSSMETTE 1 ☐ Yes 2 ☐ No 3 X Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an discess Jas autopsy Director: After this certificate | 1 Yes 2 No Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA hospup 4 Nursing Home 5 Residence filled in by the funeral 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural 5 Pending iniury 1 ☐ Yes 2 ☐ No 2 Accident Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Funeral Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one Signature and title of certifi 29d. Date signed (Month, Day, Year) March 21 2012 8303 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) M AMRON (times) 6701 N. crances ST 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

amend #5 Per INF G925 3/26/2012 JH
State of Maryland / Department of Health and Mental Hydiene

Examir	al er	4a. Facility Name (if not institution, give street and number Seasons Hospice @ Northwe	er)	4b. City, Tov	vn, or Location of Randall	Death stown	4c. County o	f Death Baltimore
Funeral Director		5. Social Security Nur 9946 232-44-9 943 Usual Residence of Decedent 6. Sex 1	Age (In yrs. las		Year If Under 2 Pays Hours		th 23, 1925	9. Birthplace (State or Fo
Maryland 28a-f show otified at	irector	10a. State 10b. County Carroll	10c. City,	Town or Location	Sykes	sville		10d. Inside City L
s 23a or nust be n	Funeral Director	7830 3rd Ave Cottage 2		10f. Zip Co	2178	84	10g. Citizen of Wh	nat Country? U.S.A.
permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced 12. Was Decede Armed Force 1 Yes 2 If Yes, Give Year or Dates	s? No		of Hispanic Origi Cuban, Mexican, No Specify:	in? (Specify Yes or No- Puerto Rican, etc.)	14. Race - Black, Specify:	- American Indian, White, etc. White
within 72 hou giene. er than "nat , the Medic a	Completed by	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4-5-4)	or 5+)	16a. Decedent's Usual O (Give kind of work d life. DO NOT use ret	ccupation one during most (ired) Teacher	of working	16b. Kind of Bus	iness/Industry
d be filed Mental Hyg arked oth	To Be	17. Father's Name (First, Middle, Last) Howard H	(ramer		18. Mother	's Name (First, Middle, Gra	Maiden Surname) ce Lillian B	ooth
d 2 should alth and N 27 is ma er trauma		19a. Informant's Name/Relationship (Type, Print) Janet Mengel Daughter	10	19b. Mailing Address (St 10382 Beller	reet and Number ive Lane B	or Rural Route Numbe erlin, MD 2181	er, City or Town, Sta	te, Zip Code)
Page 1 an nent of He ant: If iten Iry or othe		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State ☐ Donation 5 ☐ Other (Specify)	ate 20b. Pla	ce of Disposition (Name of metery, crematory or othe est Lawn Memorial	of place) Gardens	Date Mar 23, 2012		ity or Town, State tsville, Marylan
permit. Departr Importa any injt		21. Signature of Funeral Service Licensee	tuni	22. Name 31 4 & 3871	k Funeral Ho Old Columb	ome, P.A. Dia Pike Ellicott (City, MD 21043	3
Ph _y si i n Medical Examiner	Examiner	Sequentially list conditions, b.	sed the death. line. As a conseque as a conseque	nce of):	dying, such as ca		rest,	Approximate Interval Betwee Onset and Dea
icate be e physiciar s the buri	ledical	that initiated events resulting in death) Last C. Due to (or a d.	as a conseque					
requires that the death certifices been signed by the attending should be detached for use a	Physician/N	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown 23c. If yes, outcor 1 Live Birl 4 Pregnar 9 Unknown	nt at time of de	ey death 3 Ectopic preg ath 5 Other (specif			23d. Date Monti	
uires that in signed build be det	þ	Part II. Other significant conditions contributing to deat	n but not resul	ting in the underlying caus	se given in Part I.			ute to the cause of death
aw req	Completed	25. Was case referred to medical				1 Tes	psy pri- prmed? de	ere autopsy findings avai or to completion of caus ath? Yes 2 \(\sum \text{No} \)
n: The la ficate ha or, page	To Be	examiner? 1 Yes 2 No	njury 2 Day, Year) 2 Injury - At hom	R/Outpatient 3 DOA 8b. Time of injury 28c.	Other: 4 Nursellnjury at work? 1 Yes 2 N	10	now injury occurred	Epecif P P C
Attending Physician: The law rr death. sctor: After this certificate has by the funeral director, page 2			etc. (Specify)			City or Tou		
soptial or Attending Physician: The I hours after death. Ineral Director: After this certificate h by filled in by the funeral director, page	Certificate:	building, 29a. Certifier 1 Certifying Physician: To the best	of my knowled	dge, death occurred at the	time, date and p	lace, and due to the ca	ause(s) and manner	as stated.
To the Hospital or Attending Physician: The law requires that the death certif within 24 hours after death. To the Euneral Director, After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use a	Medical Certificate:	building,	of examination a	and/or investigation, in my o knowledge, death occurre	pinion, death occ	urred at the time, date a and place, and due to	and place, and due to the cause(s) and mar 29d. Date signed (o the cause(s) and manne nner as stated.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item I per doc g925 3-21-12 vt
State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) **Elbert** Sylvaneous Tea1 2. Date of Death 3. Time of Death Physician/ Month AUMEOR 0.3 2012 12:10PM Medical a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Medical Baltimore Maryland N/A Center Social Security Number 8. Date of Birth (Month, Day, Year) 6. Sex **Funeral** 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 212-34-6476 Min. Director 1 XM 2 🗆 F 74 Usual Residence of Decedent 11/28/1937 Georgia show notified at 10a. State 10b. County 10c. City, Town or Location Director 10d. Inside City Limits · 28a-f 1x Yes 2 □ No MD N/A Baltimore 10e. Street and Number ò 10f. Zip Code ems 23a or must be r 10g. Citizen of What Country? Funeral 1700 Westwood Ave. 21217 S.A. items 2 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces?

1 ☑ Yes 2 ☐ No If Yes, Give Year or Dates. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, ed other than "natural", or iter event, the Medical Examiner Black, White, etc. 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 1 Yes 2 No Specify Specify: Black 3 Widowed 4 Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) 12th Grade College (1-4 or 5+) should be filed with and Mental Hygien is marked other ti Mixer Havens Chemical Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be f Department of Health and Menta Important: If item 27 is marked any injury or other traumatic ev 2 Elbert Teal Ella Ma e Holland 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Gennora Brown(daughter) 112 S. Carlton St., Baltimore, MD 21223 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State Conation 5 Other (Specify) on-site Crematory 03/20/12 Baltimore, MD f Funeral Service Licensee 21. Signature Joseph H. Brown Jr. Funeral Home PA 2140 N. Fulton Ave., Baltimore, MD21217 once. Approximate Interval Between Onset and Death Physician/ Metabolic Acidosis Medical resulting in death) Due to (or as a consequence of): Examiner lostrudium Sequentially list conditions, Examine Due to for as a consequence on if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): nding physician a use as the burial-Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 Yes 2 No for Pregnant at time of death Month signed by tl Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Kidney Disease Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? hypertension 24a. Was an page 2 has autopsy performed? 1 Yes 2 No 1 ☐ Yes 2 ☐ No director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital 1 ☐ Yes 2 🔀 No Other: 4 \(\text{Nursing Home} \) 5 \(\text{Residence} \) 6 \(\text{Other} \) Other (Specify) မ 1 Inpatient 2 ER/Outpatient 3 DOA funeral of 28a. Date of injury (Month, Day, Year) 27, Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 🔀 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: Af completely filled in by the fu 24 hours after death. Funeral Director: A ☐ Accident☐ Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide determined Medical 29a, Certifier ☑ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) M.J 3 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) NAMAN DESAI LA Medical Center 10. N Green St Baltimore MD 21201

DHMH 17 Rev 06-2011

State

Registrar

31. Date filed (Month, Day, Year)

MAR 21

32.

2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

2012 08858

		1- For State Registrar	C	Certificate of	Death	R	eg. No.	2 0000
Physici	an/	Decedent's Name (First, Middle,La.	st)			2. Date of Dea Month		3. Time of Death
Medical Exami	ner	Victor Udoff				March 1,	2012	1853 hrs
		4a. Facility Name (if not institution, given St. Agnes Hospital	e street and number)	41	o. City, Town, or Location of Baltimore		4c. County of Deat	
Funeral Director		5. Social Security Numberink 6. S	ex 7. Age (In your 1991) 7. Age (In your 199	rs. last birthday)	If Under 1 Year If Under Months Days Hours	Min	Forei	irthplace (State or unk ign ountry)
		Usual Residence of Decedent	JWI ZLIF OT	Yrs.		July 1	0, 1947	ountry)
any		10a. State 10b. County	10c. (City, Town or Locatio	n			10d. Inside City Limits
Maryland 28a-f show	5	MD Balti	more	Catonsvil	.1e			1 Yes 2 No
Maryland 28a-f sho d at once.	Director	10e. Street and Number			10f. Zip Code	1	0g. Citizen of What Cou	untry?
ith the M 23a or 2		55 Wade Ave.			21228		USA	
MD 21215-0036 d 2 should be filed within 72 hours after death with the Maryland th and Mental Hygiene. n 27 is marked other than "natural", or items 23a or 28a-f sho numatic event, the Medical Examiner, must be notified at once	Funeral	11. Marital Status unk 1 Never Married 2 Married	1 Yes 2 N	K If Yes	Decedent of Hispanic Orig s, specify Cuban, Mexican,		White, etc.	rican Indian, Black,
rs afte ural",	ğ	3 Widowed 4 Divorced 15. Decedent's Education (Specify o	If Yes, Give Year or Dates:	-	es 2 No specify: Usual Occupation (Give l	and of work donol 170 kg	Specify: whi	ite
2 hour	ted	Elementary/Secondary (0-12)	College (1-4 or 5+)	during mos	t of working life. DO NOT	use retired)	, 16b. Kind of Business	industry UTIK
5-0036 lled within 72 he Hygiene. I other than "n. the Medical Ex	Completed	unk	unk					
5-0036 lled within 7 Hygiene.	ပ္ပြဲ	17. Father's Name (First, Middle, Last	unk		18.Mother	s Name (First, Middle, I	Maiden Surname) un l	c
2121 Mental H marked c event,	Be							
Baltimore, MD 21215-00; permit. Pages I and 2 should be filed with Department of Health and Mental Hygiene Important: If item 27 is marked other thinjury or other traumatic event, the Mec	၉	19a. Informant's Name/Relationship (1	'ype, Print)		Address (Street and Num			
, MD and 2 sho ealth and cm 27 is		20a. Method of Disposition	120		W. Baltimore	Date	more, MD 21 20c. Location - City or	
Baltimore, permit. Pages 1 at Department of He Important: If ite		1 Burial 2 Cremation 3	Removal from State	crematory or othe		bac	200. Eddallon - Oldy Ol	Town, State
Itimen ritmen y or c	- 1	4 Donation 5 X Other Specify	in state	22 No	me and Address of Facility	Chaha	1 - D 1	
Ba perm Depa Imp	-	21. Signature of Funeral Solvice Licer On all d	Verytreeto		55 W. Baltim			21201
Physician	-	23a. Part I. Enter the disease, or com	flications that caused the de					Approximate Interval
/Medical /xaminer		failure. List only one cause on ea	Asphyxia					Between Onset and Death
Adminer		or condition resulting in death)	Due to (or as a consequence					
	_	dequentially list contaitions,	Choking on f					
	틀	cause. Enter Underlying Cause (Disease or injury that initiated	Due to (or as a consequenc	Je 01).				
ed isit	Exar	events resulting in death) Last	Due to (or as a consequence	ce of):				
760, icate be executed physician and the burial - transit		d. X UNPENDED	AMENDED 23a-b	.pt.II.27	28a-f.per me	2.0925 3-23	-12 sm	
760, icate be execut physician and the burial - tra	Medical	IF FEMALE:	23c. If yes, outcome of pr				23d. Date of deliver	
		23b. Was decedent pregnant in the past 12 months?	1 Live birth		death 3 Ectopic	pregnancy		y Day Year
Box 68: death certiff the attending of for use as	sici	1 Yes 2 No 9 Unknowr	Pregnant at time of	f death 5 Othe	r (Specify)		1	
that the dended by the	Physician	Part II. Other significant conditions	9 UNKNOWN	ot resulting in the unc	tertying cause given in Par	t I 23e Did to	bacco use contribute to	the cause of death?
of Vital Records, P.O. ng Physician: The law requires that th ther this certificate has been signed by meral director, page 2 should be detach	اھ	Schizphrenia	30.00.200.300.000	or rooming in the direct	ionymg saddo giron in i di		2 ✓ No 3 Prol	
ds, equire een si ould b	Completed					24a. Was a		utopsy findings available
COT law r has b	힡					autop:	med? death?	completion of cause of
tal Recian: The certificate ector, page		25. Was case referred to medical			26.Place of Death (Chark only one)	2 No 1 Y	es 2 No
Vital ysiciar his cer	o Be		lospital: 1 Inpatient 2	✓ ER/Outpatient	Tou.	Nursing Home 5	Residence 6 Other	r:
Of Ning Phy	-	27. Manner of Death	28a. Date of Injury (Month, Day, Year)	28b. Time of Inju		28d. Describe h	now injury occurred	
ion tendir eath. or: A	텵	1 Natural 5 Pending 2 X Accident Investigati	£4 2 1 12	fd 6:30	1 Yes 2 X	No subject	choked on	food bolus
Division tal or Attendir rs after death. al Director: A	iffic	3 Suicide 6 Could not	be 28e. Place of Injury - A		factory, office building, etc	28f. Location (S	Street and Number or Rutate) 55 Wade A	ural Route Number, City
Division of Vital Records, P.O. Box 68 Hospital or Attending Physician: The law requires that the death certif 24 hours after death. Functal Director: After this certificate has been signed by the attending tely filled in by the funeral director, page 2 should be detached for use as	Certification:	4 Homicide determine	(Specify) men	tal healt	h(state)	Catonsv	ille,MD.	ive.
Division To the Hospital or Attent within 24 hours after death To the Funeral Director:	edical	1	an: To the best of my knowledge. On the basis of examination and manner stated.					
H 3 H 8	¥	29b. Signature and title of certifier			29c. License number		29d. Date signed (Mo.	nth, Day, Year)
		0-2-			O.C.M.E.		March 3, 2012	
	İ	30. Name and address of person who			/ Dalking Cr	Dalkin	200	
			Assistant Medical Ex		/. Baltimore Street, I	Baitimore, MD 212		
St Regist	ate rar	31. Date filed (Month, Day, Year)	12 Several Sign	A. gar				

OCME

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ 2012 Jane Burbank Wyrick Medical 4a, Facility Name (if not institution, give street and number) **Examiner** City, Town or Location of Death 4c. County of Death timore 1 Year If Under 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** June 15, Year) 921 1 □ M 2 🗓 F Months Hours Min Maryland Director 579-18-2156 90 Usual Residence of Decedent 28a-f show aţ 10a. State 10c. City, Town or Location 10d. Inside City Limits Director Examiner must be notified 1 🗆 Yes 2 🖁 No Parkville MD Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a or Funeral 21234 8720 Emge Rd. items Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11 Marital Status 14. Race - American Indian Armed Forces? Black, White, etc. ò ò 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 🕅 No Specify: If Yes, Give Year or Dates Specify: white "natural", 3 Widowed 4 X Divorced Completed event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working and Mental Hygiene. is marked other than life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) secretary insurance company Be 17. Father's Name (First Middle Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ John Burbank MacDonald Helen Dobson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 st Department of Health a Important: If item 27 is any injury or other tra 6004 Plummer Ave; Baltimore, MD 21206 Frank Wyrick - son Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place) ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 X Donation 5 Other (Specify) Ronal d 22. Name and Address of Facility State Anatomy Board 655 W. Baltimore St; Baltimore, MD 21201 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line. shock. Interval Between Immediate Cause (Final Onset and Death Physician/ umany Ne disease or condition Medical resulting in death) as a consequence of) / Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying -transit Cause (Disease or iinjury that initiated events Due to (or as a consequence of): resulting in death) Last burialphysician Physician/Medical that the death certificate be Records, P.O. Box 68760 the use as 1 attending IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?

1 Yes 2 No
9 Unknown Month Pregnant at time of death signed by the a Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? à 1 Yes 2 No 3 Probably 4 Dunknown Completed Were autopsy findings available prior to completion of cause of death? 24a. Was an autonsy page 1 ☐ Yes 2 ☐ No Yes Division of Vital To the Hospital or Attending Physician: Be 25. Was case referred to medical 26. Place of Death (Check only one) 2 No Hospital မ 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) After this 28b. Time of 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28c. Injury at 28d. Describe how injury occurred Natural work? 1 🗌 Yes 2 🗀 No 5 Pending iniury s after death.

I Director: Aff 2 Accident
3 Suicide Investigation 6 Could not be within 24 hours after de
To the Funeral Directo
completed filled in by th 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and the certifier 29d. Date signed (Month, Day, Year)

State Registrar 30. Name and address

31. Date filed (Month, Day, Year

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 [] | 2 For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death ARU Physician/ FELENS 2012 Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death **Examiner** 4b. City, Town, or Location of Death Anne Arundel Medical Center Anne Arundel Annapolis 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2 X F Months Days Hours Min (Month, Day, Director 214-38-2316 194 70 6. <u>Maryland</u> Usual Residence of Deceden show 10a. State er than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at 10b. County 10c. City. Town or Location 10d. Inside City Limits Director MD Anne Arundel Arno1d 1 Yes 2 XNo 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code Funeral 1206 Brunswick Ct. 21012 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces? Black, White, etc. 1 Never Married 2 X Married þ Baltimore, Maryland 21215-0036 white If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: Specify. Completed 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry should be filed within 72 and Mental Hygiene. life, DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 2 healthcare 12 medical office permit. Page 1 and 2 should be filed v Department of Health and Mental Hyg Important: If item 27 is marked othe any Injury or other traumatic event; Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Mary Joan Dlabich Peter Paul Klimczak 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
748 Stinchcomb Rd; Severna Park, MD 21146 19a. Informant's Name/Relationship (Type, Print) Joan M. Larimer - sister 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place, ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 X Donation 5 Other (Specify) Rona I 22. Name and Address of Facility State Anatomy Board 655 W. Baltimore St; Baltimore, MD 21201 nn Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset/and Death Immediate Cause (Final Ph. sician/ disease or condition Medical resulting in death) Due to (or as a consequence of Examiner Sequentially list conditions, Due to (or as a consequence of) if any, leading to immediate cause. Enter Underlying Exami To the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury that initiated events and -tran Due to (or as a consequence of) resulting in death) Last attending physician for use as the buria Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregna 5 Other (specify) in the past 12 months? Month Day Year Pregnant at time of death Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably ◆☐ Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe this certificate Yes 2 No 25. Was case referred to medica Be 26. Place of Death (Check only one) Other: 4 \square Nursing Home 5 \square Residence 6 \square Other (Specify) 2 No 1 Tes မ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director: After to completed filled in by the funeral 1. Natural 5 Pending 1 🗌 Yes 2 🗌 No 2 Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie EFENSE HWY NNAPOLI Registrar's Signat State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ March 1 3 2012 6:27 P M Daniel Frederick Weitzel Jr. Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death **Examiner** 4b. City, Town, or Location of Death Queen Anne 107 Church Lane Barclay If Under 1 Year | If Under 24 Hrs. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days Hours Sept 5, Maryland 216-65-5653 57 Director 1 🛛 M 2 🗆 F Usual Residence of Decedent show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits the Maryland Director notified 28a-f 1 Yes 2 X No MD Queen Annes Barclay 10e. Street and Number 10f. Zip Code 5 10g. Citizen of What Country? must be 23a Funeral 107 Church Lane 21607 USA 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, "natural", or ite unk Black, White, etc ò 1 Never Married 2 Married 1 Yes 2 X No If Yes, Give Page 1 and 2 should be filed within 72 hours after Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. Specify: White Completed 3 Widowed 4 Divorced Year or Dates. the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) self employed 12 electrical nt of Health and Mental Hygi If item 27 is marked other or other traumatic event, t Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) မ Phyllis Hope Rydmond Daniel Frederick Weitzel Sr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Celeste Franks - friend 107 Church Ln; Barclay, MD 21607 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Department or Important: If any injury or once, ☐ Burial 2 ☐ Cp 3 Removal from State 4 Donation 5 Other (Specify) 22. Name and Address of Facility State Anatomy Board 21. Signatu Rona Ld 655 W. Baltimore St; Baltimore, MD 21201 Enter the dise rie, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, r heart failure. List only one cause on each line. Approximate shock Interval Between Immediate Causanial Physician/ Anlliv disease or condition resulting in death) ANLTRAS Y ZA Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): The law requires that the death certificate be executed and the burlal-trai that initiated events Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 as IF FEMALE 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Day Year Pregnant at time of death Unknown been signed by the a should be detached 1 Yes 2 No g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Completed by mr wyat 1 1 Tes 2 6 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy performed? 2 🗌 No Yes 2 No 1 🗌 Yes Hospital or Attending Physician: 25. Was case referred to medical funeral director, Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No မ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred after death. Director: After 1 Natural 5 Pending work 1 Yes 2 No Accident Investigation filled in by the 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 24 hours Medical 1 Gertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated within 2. 3 🗌 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29h. Signature and title of certific 29d. Date signed (Month, Day, Year)

State Registrar 31. Date filed (Month, Day, Year)

108

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. F

gistrar's Signatu

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

amend #19b Per FH G927 5/08/2012 JH
State of Maryland / Department of Health and Mental Hygiene 20 2

AMEND ITEM#10e, perINF, G927 5/22/2012, WS

Certificate of Death

Reg. No. 08862 1 - For State Registrar Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Year 19:48P M Withersoon revtelle 2012 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death University of Medical Center Maryland 1-tomore Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs. Social Security Number 6. Sex 7. Age (In vrs. last birthday) 8. Date of Birth **Funeral** Months Hours Min. (Month, Day, Year) 248-74-0616 **Director** 1 □ M 2 💢 F 65 Dec.11,1946 South Carolina Usual Residence of Decede 28a-f shov 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits with the Maryland ms 23a or 28a-f sho must be notified at Director 1 X Yes 2 ☐ No Maryland Baltimore 10e. Street and Stafford 10f. Zip Code 10g. Citizen of What Country? Funeral 21229 U.S. A 3134 Sanford Street Page 1 and 2 should be filed within 72 hours after death ment of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or items 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, the Medical Examiner Black, White, etc. 9 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: Specify: Black Completed 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. is marked other than Elementary/Secondary (0-12) 12 College (1-4 or 5+) Line Supervisor Food Be injury or other traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည James Witherspoon Lottie Spates 19a. Informant's Name/Relationship (Type, Print) 19b Mailing Aldress (Street and Number of Rural Route Number, City or Town, State, Zip Code) 2178 Pope Street, Turbeville, South Carolina 29162 Lottie S. Witherspoon/Mother 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date Department of H Important: If ite any injury or oth once. 1 🙀 Burial 2 □ Cremation 3 □ Removal from State cemetery, crematory or other place) Donation 5 Other (Specify) Hickory Grove 3-18-12 Turbeville, South Carolina permit. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Marzullo Funeral Chapel, P.A. 6009 Harford Road, Baltimore, Maryland 21214 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Physician/ Metastatic disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Physician/Medical Examiner Due to (or as a consequence of): Cause (Disease or injury for use as the burial-tran that initiated events resulting in death) Last and Due to (or as a consequence of): signed by the attending physician d be detached for use as the burial To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physicis completely filled in by the funeral director, page 2 should be detached for use as the bu Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown 4 Pregnant 9 Unknown 5 Other (specify) Month Day Year Pregnant at time of death Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Disease Antery Coronary 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed Yes 2 1 Yes 2 No 25. Was case referred to medical examiner?

1 Yes 2 No Be 26. Place of Death (Check only one) 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify, Hospital: ည 1 Ninpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred Natural injury 5 Pending Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) ☐ Homicide determined Medical 1 🙎 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 3 only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 2565 13 who completed cause of death (Item 23a) (Type, Print) Baltimore MD 5. Greene Ma 31. Date filed (Month, Day, Year) State MAR 21 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #20b State of Maryland / Department of Health and Mental Hygiene 08863 For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ March 18^{Day} 2012 Walters (aka) Mike Washington Walters 1:45 P M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Sykesville Carrol1 Transitions Healthcare 8. Date of Birth (Month, Day, Y Sep. 28, If Under 1 Year If Under 24 Hrs. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Year) 1964 Min. **X X** M 2 □ F Hours Country) 47 Director 484-78-5543 Sep. Usual Residence of Decedent ntal Hygiene. ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 72 hours after death with the Maryland Director XX Yes 2 No MD Carroll Hampstead 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21074 4041 Gill Avenue, Apt. #105 U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14 Race - American Indian Armed Forces?
1 ☐ Yes 2XXNo Black, White, etc. 1XXNever Married 2 ☐ Married þ 1 ☐ Yes 2XXNo Specify: Specify: White If Yes, Give 3 Widowed 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) should be filed with and Mental Hygien 7 is marked other t 12th Tile Mechanic <u>Construction</u> Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) rmit. Page 1 and 2 should be f partment of Health and Menta portant: If item 27 is marked y injury or other traumatic ev ည Larry Milo Wlaters Valley Grey Roughton 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Richard Milo Walters (Brother) 4041 Gill Ave., Apt. #105, Hampstead, MD 21074 20a. Method of Disposition Date Unk. 20b. Place of Disposition (Name of 20c. Location - City or Town, State Department of H Important: If ite any injury or ot All Faiths 1 Burial XX Cremation 3 Removal from State 03/29/2012 Hanchester, MD 4 Donation 5 Other (Specify) Chape1 f Fure Solice Licens

MOVMAU 22. Name and Address of Facility Eckhardt Funeral Chapel, P.A. 3296 Charmil Dr. Manchester, MD 21102 . Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest lock, or heart failure. List only one cause on each line. Onset and Death Fnysician/ CHRONIC OBSTRUCTIVE NUMONARY DISEASE disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to infinediate cause. Enter Underlying Due to (or as a consequence oi). Exami physician and s the burial-transit Cause (Disease or linjury that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical attending place as the IF FEMALE 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? 1 Yes 2 No 9 Unknown ģ Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? b 1 Yes 2 No 3 Probably 4 Unknown cate has been sig , page 2 should b Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy certificate 1 ☐ Yes 2 ☐ No Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital 1 ☐ Yes 2 ☑ No Other: 1 Inpatient 2 ER/Outpatient 3 DOA ျ 4 Nursing Home 5 Residence 6 Other (Specify, Director: After this of in by the funeral dir 27. Manner of Death 1 Natural 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 5 Pending injury work? 1 Yes 2 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide filled in by determined

Hospital or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760

Baltimore, Maryland 21215-0036

24 hours a Funeral D

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

M.D. 1838 GREENE TRED RUAD # 300 PILETULLE MP 2:208 LEONARD RICHARDSON 31. Date filed (Month, Day, Year 32. Registrar's Signature

Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

D57722

29c. License number

City or Town, State)

29d. Date signed (Month. Day, Year)

MARCH 20

2012

State

Registrar

Medical

29a. Certifier

(Check

29b. Signature and title

MAR 2 1 2012

M.D.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death Physician/ Month 3 WEDDINGTON 2512 08:00 AM Medical ty Name (if not institution, give **Examiner** 4b. City, Town, or Location of Death 4c. County of Death SALTMORE JECORS N DITITAL If Under 24 Hrs. Birthplace (State or Foreign Country) Age (In yrs. last birthday) 8. Date of Birth **Funeral** Months Min Month Bay, 65 **Director** or 28a-f show 10a. State permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: I fitem 27 is marked of other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event, the Medical Examiner must be notified as Director 10c. City, Town or Location 10d. Inside City Limits Baltimore Ma 1 ₽Yes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral [430 21201 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married ☐ Yes 2 X No Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. Specify: Black Completed 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) rlas Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname 19b. Mailing Address (Street and Number or ral Route Number, City or Town, State, Zip Code) 30 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Saltu. -26-2012 21. Sign turn of Funeral Service License Funeral 23a. Part 1. Enter the disease, or complications that odused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death Ph_sician/ disease or condition resulting in death) Medical Due to (or as a cor Examiner Sequentially list conditions, if any, leading to immediate cause Enter Underlying Examiner Due to (or as Cause (Disease or iinjury that initiated events resulting in death) Last Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: DA 23b. Was deceded pregnant 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Dav Pregnant at time of death 2 No After this certificate has been signed by the funeral director, page 2 should be detached g Unknown g 🗌 Unknown Part_II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an performed? Yes 2 No 1 ☐ Yes V No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital Other: ျ 1 Yes 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DCA 4 Nursing Home 5 Residence 6 Other (Specify Manner of Death Date of injury 28b. Time of Certificate: 28c. Injury at work? 28d. Describe how injury occurred Natural (Month, Day, Year) 5 Pending injury 1 Yes 2 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 24 hours a Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and M.D, 2012 070720 who completed cause of death (Item 23a) (Type, Print) 2000 State Registrar DHMH 17 Rev 7/2009

1/

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death . 2<u>012</u> MILL MARCH 17 1:45 P M 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 6101 EVERY SAIL PATH CLARKSVILLE HOWARD 5. Social Security Number 7. Age (In yrs, last birthday, If Under 1 Year I If Under 24 Hrs 8. Date of Birth Birthplace (State or Foreign Country) 1**X**□ M 2 □ F Months Days Hours Min. 0170571926 216-14-8660 86 Yrs MD Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 😿 No HOWARD CLARKSVILLE 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? 6101 EVERY SAIL PATH 21029 USA 12. Was Decedent Ever in U.S Armed Forces? 1 Xyes 2 No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 X Married 1 ☐ Yes 2 XNo Specify: 3 Divorced Specify: Year or Dates WHITE 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 12 OWNER INSURANCE 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) JULIUS WALDERMAN ANNA GREENFIELD 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) CAROLE WALDERMAN/WIFE 6101 EVERY SAIL PATH, CLARKSVILLE, MD 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) Donation 5 Other (Specify) DRUID RIDGE CEMETERY 03/20/2012 BALTIMORE, MD 21. Signature of Funeral Service Lin 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) dispusp PIMPN Due to (or as a consequence of): Due to (or as a consequence of): yes, outcome of pregnancy
Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 Yes 2 No Year Month Pregnant at time of death Day 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown

Ph sician/ Medical Examiner Examine sician and burial-tran

the attending p for use as t

page 2

within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director,

ģ

Completed

Be

မ

Certificate:

Medical

that the death certificate be

Hospital or Attending Physician: The law requires

Division of Vital Records, P.O. Box 68760

Physician/

Medical

10a. State

MD

Examiner

Funeral

Director

items 23a or 28a-f show ner must be notified at

er than "natural", or ite the Medical Examiner

ماله المالية على مرابع filed with. معلم Hygiene. موسل المالية المالية المالية المالية المالية المالية المالية المالية المالية المالية المالية الم

and Mental Hygie is marked other other traumatic event,

1 and 2 s of Health a item 27

Department of Important: If it any injury or o

Baltimore, Maryland 21215-0036

Director

Funeral

þ

Completed

Be

ည

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Physician/Medical

IF FEMALE:

24a, Was an autopsy performed

24b. Were autopsy findings available prior to completion of cause of death? 1 🗌 Yes 2 🗌 No

25. Was case referred to medical examiner?
1 ☐ Yes 2 No 2 No 27. Manner of Death Natural

Accident

Homicide

Suicide

29a. Certifier

(Check

5 Pending Investigation 6 Could not be

determined

1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Hospital:

28b. Time of injury

28c. Injury at work? 1 Yes 2 No

Other:

26. Place of Death (Check only one)

4 ☐ Nursing Home 5 KResidence 6 ☐ Other (Specify)

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State) Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and

29d. Date signed (Month, Day, Year)

death (Item 23a) (Type, Print) and address of person who completed cau 18

State Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death ecedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death Examiner Clotte 10 Social Security Number 7. Age (In yrs. last birthday If Under 1 Year If Under 24 Hrs. 8 Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 X M 2 1 F Min 8 Tennessee Director Usual Residence of Decedent item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at build be filed within 72 hours after death with the Maryland d Mental Hygiene.
marked other than "natural", or items 23a or 28a-f sho 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No Prince Georges Upper Marlboro 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 8804 Pensicola Pl. 20622 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S.
Agned Forces?
12. Yes 2 No 195
If Yes, Give 1 95 11. Marital Status 14. Race - American Indian Black, White, etc 1950-1 Never Married 2 Married Completed by Maryland 21215-0036 **Black** 1 ☐ Yes 2 🕅 No Specify: 3 ₩idowed 4 □ Divorced 1951 Year or Dates Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) self employed travel industry Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Lillian Ernestine Jones Curl Anthony Young Sr. 1 and 2 should to of Health and Me item 27 is mark 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1221 M. St Apt 1019; Washington, DC 20005 Curl A. Young Jr. - son Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of permit. Page 1 a
Department of H
Important: If ite
any injury or ot Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☒ Donation 5 ☐ Other (Specify) cemetery, crematory or other place, Signature of Funeral Service 22. Name and Address of Facility State Anatomy Board 655 W. Baltimore St; Baltimore, MD Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Retween mediate Cause (Final n et and Deat Physician disease or condition nonths Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, it any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Examin Cause (Disease or linjury that initiated events Due to (or as a consequence of): resulting in death) Last burialphysician s the burial Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Box 68760 attending p for use as t IF FEMALE 23c. If yes, outcome of pregnancy 1 \square Live Birth 2 \square Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ Dav Year Pregnant at time of death the Unknown 9 Unknown P.O. I signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an Jas page OBSTRUCTIVE performed? certificate 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital Other: 2 NO မ 1 Tes After this c 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify, 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: injury 1 Natural 5 Pending M Accident Investigation within 24 hours after death

To the Funeral Director:

completed filled in by the Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 3 🗆 only one 29b. Signati

State Registrar 31. Date filed (Month, Day, Year)

person who completed cause of death (Item 23a) (Type, Print)

12-01882 Unk Unk

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

		1- For State Registrar	,	Cei	rtificate c	of Death		15	Reg. No			
Physic		1. Decedent's Name (First, Midd	ile,Last)					2. Date of I			3. Time of Death	
Medical Exam	inei	Denise Zarzo						March	5, 2012	<u> </u>	0835 nrs	
		4a. Facility Name (if not institution 3530 East Fairmount		nber)		4b. City, Town, Baltimore	or Location of	of Death	4	tc. County o	of Death	
Funeral		5. Social Security Number	6. Sex	7. Age (In yrs. I	ast birthday)	If Under 1 Ye			Birth (MI	M/DD/YYYY	9. Birthplace (State or	
Director		214-86-3258	1 M _2_X F	52	Yr	s. Months Da	ays Hours	Min. May 2	28, 1	959	Foreign CountryMaryland	
any		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location										
* .	L	MD			altimo						10d. Inside City Limit 1 X Yes 2 N	
Maryland 28a-f show 1 at once.	Director	10e. Street and Number				10f. Zip Code		' '	10g. Či	tizen of Wh	at Country?	
more, MD 21215-0036 Pages I and 2 should be filed within 72 hours after death with the Maryland tent of Health and Whorlal Hygiens and Wastural", or items 23a or 23a-f sho wit If them 17 is marked other than "natural", or items 23a or 23a-f sho or other traumatic event, the Medical Examiner must be notified at once.	_	1002 E. 20th	St.			2121	8		Ţ	JSA		
ath wir	unera	11. Marital Status 1 XNever Married 2 M	12. Was Dece					in? (Specify Yes or Puerto Rican, etc.)	No-	14. Race White	- American Indian, Black, , etc.	
fter de l'', or	y Fu	3 Widowed 4 Div	orced If Yes, Give Year	2 X No	1	Yes 2X N	o specify:			Specify:	white	
nours a natura ixamin	q pe	15. Decedent's Education (Spe	cify only highest grade	e completed)	16a. Decede		ation (Give I	kind of work done	16b.		siness/Industry	
0036 within 72 h iene. er than "n Medical E	Completed	Elementary/Secondary (0-12)	,	4 or 5+)		_		use retirea)		1	34.134	
5-0036 iled within 7 Hygiene. I other than the Medica	Com	9 17. Father's Name (First, Middle	Last)		not	ısekeepi		s Name (First, Middl	e Maider		oitality	
ID 21215-00%; should be filed withing and Mental Hygiene, it is marked other the matic event, the Med	Be (Thomas Vince	nt Zarzour					s Skinner	o, maidei	r ourname)		
21 hould nd Me is ma:	1º	19a. Informant's Name/Relations						ber or Rural Route				
ore, MD 2 is 1 and 2 shou of Health and N If item 27 is neer traumatic		Lois Zarzour 20a. Method of Disposition	- mother	130b F		27 Cathe					re, MD 21201	
Baltimore, M permit. Pages I and 2 Department of Health Important: If item 2 injury or other traum		1 Burial 2 Cremation		m State C	rematory or of		emetery,	Date	20c.	Location -	City or Town, State	
Baltim permit. Pa Departmen Important Injury or or		4 Qonation 5 X Other S	pecify: in sta	te	22	Name and Addres	s of Facility	G				
Balt permit Depart Impor Injury	· W	Ron d	D. D.	ire ctor				State Ana ore St; Ba				
Physician	1	23a. Part I. Enter the di ease, or failure. List only one cause	complications that cau	used the death.	Do not enter t	he mode of dying	, such as ca	ardiac or respiratory	arrest, sh	ock, or hea	rt Approximate Interva Between Onset and	
/Medical Examiner		Immediate Cause (Final disease or condition resulting in death)				Intoxica	ation				Death	
to any other		Sequentially list conditions,	Due to (or as a c	consequence of):							
	iner	if any, leading to immediate cause. Enter Underlying Cause	Due to (or as a c	onsequence of):							
	Examiner	(Disease or injury that initiated events resulting in death) Last	c. Due to (or as a c	consequence of):							
760, icate be executed physician and the burial - transi												
760, cate be ex physician he burial	Medical	WINDERDED AMENDED 23a, pt. 11, 27, 28a-f, per me, g925 3-23-12 sm AMENDED 23a, pt. 11, 27, 28a-f, per me, g925 3-23-12 sm If FEMALE: 23d. If yes, outcome of pregnancy 23d. Date of delivery										
		23b. Was decedent pregnant in the past 12 months?	1 Live birt	th	2 Fe	tal death 3	Ectopic	pregnancy	23	d. Date of c Month	lelivery Day Year	
cath for u	Physician	1 Yes 2 No 9 V Unk		ntattime of dea	ath 5 Ot	her (Specify)						
		Part II. Other significant conditi			sulting in the u	inderlying cause	given in Par	t I. 23e. Dic	tobacco	use contrib	ute to the cause of death?	
e de de	d b	Cocaine Use						1 Y	es 2	No 3	Probably 4 Unknown	
cords law requi	olete							24a. Wa	is an opsy		ere autopsy findings available for to completion of cause of	
Division of Vital Records, tat or Attending Physician: The law requires after death. at Director: After this certificate has been siled in by the funeral director, page 2 should be in by the funeral director, page 2 should be a second to the funeral director.	Completed								formed?	de	eath? Yes 2 No	
Vital F ysician: his certifi director,	Be	25. Was case referred to medical examiner?	Hospital:			26.Place		Check only one)				
of Vital Reing Physician: The Affer this certificate Uneral director, page	욘	1 Yes 2 No 27. Manner of Death	28a. Date of		ER/Outpatient 28b. Time of I		Other ₄	Nursing Home 5			Other: Scene	
ion of tending Pheath. tor: After the funeral	Ë	1 Natural 5 Pend	(Month, D	Day,Year)			Yes 2 🛣 I			ury occurred	1	
ViSion Particular de Directo	ifica		tigation fd 3- 28e Place of		fd 0823 ne, farm, stree	et, factory, office t	ouilding, etc.	28f. Location	(Street a	nd Number	or Rural Route Number, City	
Ospital hours a uneral I	Certification:	4 Homicide deter		abandor	ed res	idence		Baltim	ore,	530 Е. MD.	or Rural Route Number, City Fairmount Av	
Division To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the	edical	29a. Certifier (Check only one) Certifying Ph	nysician: To the best on the basis of the ba	of my knowledge	e, death occur	red at the time, d	ate and plac	e, and due to the ca	use(s) an	id manner a	s stated.	
To with	Med	29b. Signature and title of certifie	and manner stat	ted /		29c Licens		arroa at the time, and			(Month, Day, Year)	
		Clus	11/	1 4	7	O.C.			i	ch 6, 20		
	1	30. Name and address of person										
			Assistant Medical				et, Baltim	nore, MD 21223	1			
St Regist		31. Date filed (Month, Day, Year)		strar's Signatur	3. A	Market					-	

2-01694		Please Type or Print in Black Indelible Ink. Ensure All C		egible.	
ohn Phillip Aw	пеу	State of Maryland / Department of Health and Men 1-For State Certificate of Death	itai Hygiene	201	2 0006
Physic	an/	Registrar 1. Decedent's Name (First, Middle,Last)	2. Date of De	Reg. No. 4 U I	3. Time of Death
Medical Exam	iner		Month	Day Year / 28, 2012	0720 hrs
		4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of		4c. County of Deal	th
		1703 Glenkarney Place Silver Spring		Montgomery	
Funeral Director		Months Days Hours	1.00	Birth(MM/DD/YYYY) 9. Bi Fore	ign
Director		219-51-4433 1X M 2 F 13 Yrs.	April	01,1998	ountry)Maryland
Å a		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits
d bow a			r Spring		1 Yes 2 X No
Maryland 28a-f sho	Director	10e. Street and Number 10f. Zip Code	T Spreate	10g. Citizen of What Cou	untry?
the M.	Ö	1703 Glenkarney Place 2090	2	11	S.A.
eath with the Maryland items 23a or 28a-f she ust be notiffed at once	E	11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Original Control of the Control of Hispanic Original Control Original	gin? (Specify Yes or N	lo- 14. Race - Ame	rican Indian, Black,
death or iter	Funeral	1 Never Married 2 Married Armed Forces? If Yes, specify Cuban, Mexican, 1 Yes 2 X No	, Puerto Rican, etc.)	White, etc.	
after ral",	by F	3 Widowed 4 Divorced If Yes, Give Year 1 Yes 2 X No specify:		Specify:	White
hours fnatu Exam		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 16a. Decedent's Usual Occupation (Give I during most of working life, DO NOT		16b. Kind of Business	/Industry
36 hin 72 than than	음	Elementary/Secondary (0-12) College (1-4 or 5+) 7 Student		Edu	cation
5-00 led with tygien other	Completed		's Name (First, Middle		Carcon
21215-0036 uld be filed within 72 hours : Mental Hygiene. marked other than "naturn c event, the Medical Exami	Be (Phillip Awtrey	Jen	nifer Borto	n
	မ	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Num			
nore, MD 2 ages I and 2 shou nt of Health and In it: If item 27 is nother traumatic		Phillip Awtrey - Father 15313 Gable Ridge 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery.	Court, Apt	L, Rockvill	e, MD 20850
Baltimore, permit. Pages I as Department of He Important: If ite		1 Burial 2 XCremation 3 Removal from State crematory or other place)			
ti Pag tment rtant:		4 Donation 5 Other Specify: Ft. Lincoln Crematory		2 Brentwood	
Baltimore, MI permit. Pages 1 and 2 s Department of Health as Important: If item 27 injury or other traum.		21. Signature of Funeral Service Licensee 22. Name and Address of Facility MO1524 11800 New Hamps			
Physician		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as ca	nure Ave ardiac or respiratory a	rest, shock, or heart	Approximate Interval
Medical		failure. List only one cause on each line. Immediate Cause (Final disease a, Hanging			Between Onset and Death
Examiner		or condition resulting in death) Due to (or as a consequence of):			
	L	Sequentially list conditions, b.			
	를	if any, leading to immediate Due to (or as a consequence of): cause. Enter Underlying Cause c.			
~ D =	Examiner	(Disease or Ir jury that initiated events resulting in death) Last Due to (or as a consequence of):			
executed in and il - trans	Sal	d.			
		UNPENDED AMENDED		12072	
876 tificat ng ph	2	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic	pregnancy	23d, Date of deliver	y Day Year
ceth certificate be estrending physicial for use as the burial	Sicia	4 Pregnant at time of death 5 Other (Specify)		1	
D. BC t the der by the a	Physician/Med	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Par	41 230 Did 1	tobacco use contribute to	the cours of death?
P.O.	á	Take the delict digital contributing to death but not resulting in the diversitying cause given in Pai	100	es 2 No 3 Prot	
ds, equire een sig	Completed		24a. Was	an 24b. Were au	ntopsy findings available
COF law r has b	힅			ormed? death?	completion of cause of
Rec i: The tificate r, page		25. Was case referred to medical 26.Place of Death (2 No 1 Y	es 2 No
/ital F rsician: rsician: his certification, I	Be			Residence 6 🗸 Other	: Scene
of \	밁	27. Manner of Death 28a Date of Injury 28b. Time of Injury 28c Injury at Work?	28d. Describe	how injury occurred	
fendir Fath.	흹	1 Natural 5 Pending Pending Investigation Peb 27, 2012 PolyNear Pending Pendin	No Subject hur	ng self	
or Ath	<u>i</u>	3 ✓ Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc		Street and Number or Ru	
spital tours a	Certification:	4 Homicide determined (Specify) Single Family Home	1703 Glerika	State) rney Place, Silver Spri	ng, MD
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physici completely filled in by the funeral director, page 2 should be detached for use as the burn.		29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred.			
To the within comp	Medical	2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurrence and manner stated. 29b- signature, and title of certifier 29c. License number	Anteu at the time, gate	29d. Date signed (Mor	
2		O.C.M.E.		February 29, 201	
	-	30. Name and address of person who completed cause of death (Item 23a)		1. 55.1441, 25, 201	
		Victor Weedn MD JD Assistant Medical Examiner 900 W. Baltimore Street, Ba	altimore, MD 212	23	
St	ate	31. Date filed (Month, Day, Year) 32. Registrar's Signature			
		MAN 113 /111 / 1/2			

DHMH 17 Rev 1/2001 OCME 2006

OCME

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last, 2. Date of Death **Physician** Month P Hella icia renas 2012 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Hagerstown HUCCISTOWN Washington NMSod If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birth lace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** Months Days, Hours 1 M 2 K F Yrs. **Director** 06/12/1938 059-36-6604 73 Columbia Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show amy injury or other traumatic event, the Medical Examiner must be notified at once. 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 1X Yes 2 □ No Directo Maryland Washington Hagerstown 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 1321 Fairchild 21742 Ave. U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 Married ☐ Yes 2 Yes, Give 2X No altimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify. þ 3 Widowed 4 Divorced Year or Dates White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker 4 Domestic 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 2 Osorio Alicia Arcinegas 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Maurice Arenas 1321 Fairchild Ave. Hagerstown, Maryland 21742 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) Smithsburg, Maryland Smithsburg Crematory 3/8/2012 22. Name and Address of Facility Rest Haven Funeral Chapel 21. Signature of Funeral Service Li 1601 Pennsylvania Ave. Hagerstown Maryland 21742 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Dreas resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine The law requires that the death certificate be executed attending physician and for use as the burial-trar Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760. Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4 ☐ Pregnant at time of death 5 ☐ Other (specify) been signed by the should be detached 9 Unknown 9 Unknow Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Tyes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? certificate has b irector, page 2 s 24a Was an autopsy 2**X** No 2□ No 1 ☐ Yes 1□ Yes Hospital or Attending Physician: director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 1 ☐ Yes 2 No 1 | Inpatient 2 ER/Outpatient 3 DOA Certification: To 4

Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Injury at Work? Injury 1 Natural 2 Accident 5 Pending investigation s after dec. eral Director: 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) within 24 29b. Signature and title of certifier 29c, License number 29d. Date signed (Month, Day, Year) Worn Mary MD 1742 Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar DHMH 17 Rev 1/2001

State

Phanic

31. Date filed (Month, Day, Year)

Ome (-

encold

32. Pegistrar's Signature

RUP

14014

Please Type or Print in Black Indelible Ink Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 2012 Physician/ 2247 helen Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Deat Examiner e Thegla N 39 DANEL 8. Date of Birth Birthplace (State or Foreign Country) Age (In yrs. last birthday) If Under If Under 24 Hrs. 6 Sex 5. Social Security Number **Funeral** Months Min (Month. Dav. Year) 108-05-0510 96 **Director** 1 □ M 2 🛛 F Jan. 26,1916 New York 28a-f show 10d. Inside City Limits 10b. County 10c. City. Town or Location Director must be notified Montgomery Rockville 1 Yes 2 No Maryland 10f, Zip Code 5 10e. Street and Numbe 10g. Citizen of What Country? items 23a Funeral 20852 United States 6050 California Circle #108 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14 Race - American Indian. Armed Forces? Black, White, etc or i þ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 within 72 hours after If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify White "natural", Completed 3 Divorced Medical 15. Decedent's Education (Specify only highest grade completed) Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Hospital Business and Mental Hygiene.

is marked other than Elementary/Secondary (0-12) College (1-4 or 5+) the Clerk Office Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) permit. Page 1 and 2 should be file Department of Health and Mental Emportant: If item 27 is marked o any injury or other traumatic eve once. မ Rose Zine Angelo Ruocco 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, 6050 California Circle #108 Rockville,MD 20852 Joseph Robert Beall (Spouse) 20b. Place of Disposition (Name of cemetery, crematory or other place)
Gate of Heaven Cem. 20a. Method of Disposition 20c. Location - City or Town, State March Date 2 1 X Burial 2 Cremation 3 Removal from State Silver Spring, MD 2012 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility DeVol Funeral Home 21. Signature of Funeral Service Licensee wites (M01116)MD 20877 10 East Deer Park Dr. Gaithersburg, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Ph_sician/ (or a consequence of): disease or condition resulting in death) 0 Medical Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events me) Examine or as a consequence of m O Due to (or as a conse resulting in death) Last Physician/Medical the as IF FEMALE: 23c. If yes, outcome of pregnanc, 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month Day Year Pregnant at time of death 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? þ 1 Tes 2 No 3 Probably 4 Unknown Records, Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an autopsy Yes 2 No 25. Was case referred to medical Vital 26. Place of Death (Check only one) Be examiner? 1 Yes Other: 4 Nursing Home 5 Residence 6 Other (Specify 2 No 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA မ of Certificate: Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred To the Hospital or Attending 5 Pending Accident Division 1 🗌 Yes 2 🗷 No Sel 14 2012 0800 Investigation within 24 hours after deatl

To the Funeral Director:
completely filled in by the 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined #108 Kockwille, MD 20852 1dome Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated
3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 13 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 15avold 4910 MASSAchubells Are #302 Whalington, D.C. 11 2/2m 31. Date filed (Month, Day, Year) State MAR 0 6 2012

Registrar

12-01711 Kim D. Blom

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 2012 08871

		1- For State Registrar		Cert	ificate of	Death			Re	eg. No.			
Physicia	n/	1. Decedent's Name (First, Middle							. Date of Deat Month		Year	3. Time of Death	
ledical Examir	ier		1y D. Blom		— т.				Month February 2			1753 hrs	
<i>)</i>		4a. Facility Name (if not institution Frederick Memorial Ho	spital			Frederick Freder							
Funeral Director			5. Sex 7. Age	(In yrs. las	st birthday) Yrs.	If Under 1 Yes	_	24Hrs. Min.	8. Date of Bird	•	Forei	rthplace (State or gnWashington D.C.	
eath with the Maryland items 23a or 28a-f show any ust be notified at once.	Director	Usual Residence of Decedent 10a. State 10b. County Maryland Frede 10e. Street and Number 136 Willowdale	rick		own or Location			110	0g. Citizen o USA	of What Cou	10d. Inside City Limits 1 🔀 Yes 2 No untry?		
fter d	eted by Funeral	15. Decedent's Education (Speci	1 Yes 2 ₽ rced If Yes, Give Year or Dates: fy only highest grade com	If Yes, specify Cuban, Mexican, Puerto Rican, etc.) W Specify Specify:						White, etc.	rican Indian, Black, White Vindustry		
5-0036 led within 72 hours a Hygiene. other than "natura other than "natura the Medical Examic	Complet	Elementary/Secondary (0-12)	College (1-4 or 5			s Coord	inator	<u>-</u>		Insur			
D 21215-0036 should be filed within 7 and Mental Hygiene. 7 is marked other than satic event, the Medica	Be Co	17. Father's Name (First, Middle, L Richard Duane					•		First, Middle, Me Denis				
AD 2121 2 should be fill 1 and Mental H 27 is marked .	2	19a. Informant's Name/Relationshi	p (Type, Print)		19b. Mailing	Address (Stre	et and Numb	er or Rur	rai Route Num	ber, City or	Town, State	e, Zip Code)	
MD d 2 sho lth and n 27 is		Vicki Wulf - si	ster									land 21702	
Baltimore, MC permit. Pages 1 and 2 si Department of Health ar Important: If item 27 injury or other traums		20a. Method of Disposition 1 Burial 2 Cremation 4 Donation 5 Other Spe		te cre	ematory or other offer C	remator	у 3	3-7-2		Frede	rick,	Town, State Maryland	
Balti permit. Departu Imports		21. Signature of Funeral Service L		2 lin	22. Na	ame and Addres	s of Facility	staui	ffer Fu	neral	Home	ryland 2170	
Physician	7	23a. Part I. Enter the disease, or c failure. List only one cause o		he death. C								Approximate Interval Between Onset and	
/Medical xaminer		Immediate Cause (Final disease	a. Cardiac Tampon	ade								Death	
. JAumior		or condition resulting in death)	Due to (or as a conse										
	5	Sequentially list conditions, if any, leading to immediate	b. Aortic Dissection Due to (or as a conse						-				
	튑	cause Enter Underlying Cause (Disease or injury that initiated	С.										
nsit	Examiner	events resulting in death) Last	Due to (or as a conse	quence of):									
760, cate be executed physician and the burial - transi	<u>8</u>	UNPENDED	d										
760, icate be ex physician the burial										23d. Dat	te of deliver	J y	
Box 687 death certific the attending p	Physician/	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 ✓ No 9 Unkn	1 Live birth 4 Pregnant at t	ime of deat		al death 3 er <i>(Specify)</i>	Ectopic p	pregnanc	у	Mon	th I	Day Year	
O. B at the d 1 by the		Part II. Other significant condition		but not res	ulting in the un	derlying cause	given in Part	l.	23e. Did to	bacco use c	ontribute to	the cause of death?	
ires that to signed by I be detace								_	1 Yes	2 🗹 No	3 Prol	bably 4 Unknown	
Division of Vital Records, P.O. Box 68: To the Hospital or Attending Physician: The law requires that the death certif within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use as	Completed								24a. Was a autops perform	sy med?	y pnor to completion of cause of ned? death?		
tal Rectant The certificate ector, page	8 B	25. Was case referred to medical examiner?				26.Place	of Death (C						
F Vit	ᆲ	1 ✓ Yes 2 No			R/Outpatient			_	Home 5 I			r.	
on of or of ath.	ţį.	27. Manner of Death 1 Natural 5 Pendir		y ar)	28b. Time of Inj		ıryat Work? Yes 2 ☐ N		3d. Describe h	ow injury oc	curred		
Division tall or Attendius after death.	Certification:	2 Accident Investi 3 Suicide 6 Could 4 Homicide	not be 28e. Place of Inju	ury - At hom	ne, farm, street	, factory, office b	ouilding, etc.	28	Bf. Location (S or Town, St		umber or Ru	ıral Route Number, Cîty	
Divisior To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the	Medical Co	29a. Certifier 1 Certifying Phy	sician: To the best of my iner:On the basis of exam	knowledge	, death occurre	ed at the time, don, in my opinion	ate and place	e, and du	ie to the cause ne time, date a	e(s) and mai	nner as stat	ed. ne cause(s)	
To the within To the comple	ğ∣	29b. Signature and title of certifier	and manner stated.	000	2	29c. Licens						nth, Day, Year)	
		Tieto Valte	i Veek	2008		o.c.	M.E.			Februar	y 29, 20°	12	
0		 Name and address of person w Victor Weedn MD JD 	ho completed cause of de Assistant Medical			Baltimore S	Street Bal	timore	MD 2122	3			
Sta		31. Date filed (Month, Day; Year)	32. Registrar	s Signature		rkel			, 1112 2122				
Registr	ar	PARTU	LUIL LEMM	1000	13. LEG C.	Char							

OCME

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 2012 Year Month 02 3:30 A Judith Blane Beachley 27 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Frederick Northampton Manor Nursing Home Frederick If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Social Security Number 8. Date of Birth 7. Age (In yrs. last birthday 9. Birthplace (State or Foreign **Funeral** Hours Month Bay Year) 9 Director 219-54-0194 1 □ M 2 🕱 F 72 Usual Residence of Decedent show 10a. State Page 1 and 2 should be filed within 72 hours after death with the Manyland ment of Health and Mental Hygiene. ant If ifew 27 is marked other than "natural", or items 23a or 28a-f sho ant If item 27 is marked other than "natural", or items be notified at ury or other traumatic event, the Medical Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No MD Knoxville Washington 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? by Funeral 2130 Boteler Rd. 21758 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces?
1 ☐ Yes 2 ☒ No Black, White, etc. 1 X Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 X No Specify: Specify: White 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) homemaker own home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ George Dewey Beachley Zillah Markoe 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mary Beachley (Sister-in-law) 8551 Indian Springs Rd., Frederick, MD 21702 20a. Method of Disposition 20th Place of Disposition (Name of Scenetery, Crematory of Other \$1500) Pa 1 20c. Location - City or Town, State 2 Crema Buria on 3 Removal from State Department of Important: If any injury or Church Cemetery 3/1/2012 Donation 🏚 🗌 Oth (Specify) Brownsville, MD 22 Name and Address of Facility
Dona Id B. Thompson
POB 18, Mddletown, ure of Funeral Servi plications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Onset and Death shock, or heart failure. List only ne cause on each line Immediate Cause (Final Physician/ disease or condition resulting in death) SUBDURAL HEMATOMA mound Medical Due to (or as a consequence of) Examiner Sequentially list conditions Examiner Due to for as a consequence of cause. Enter Underlying Cause (Disease or injury by the attending physician and etached for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical To the Hospital or Attending Physician; The law requires that the death certificate be within 24 hours after death.

To the Funeral Director, After this certificate has been signed by the attending physicial completely filled in by the funeral director mans 2 should be detected. P.O. Box 68760 IF FEMALE 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 Yes 2 No Month Day Year 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 ☐ Yes 2 ♣ No 3 ☐ Probably 4 ☐ Unknown MYELODYSPLASTIC ANOMIA Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performe Yes 2 No 2 🗌 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 Yes Other: 2 🗌 No Certificate: To 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of injury
(Month, Day, Year)

February 3,202 Unknown 27. Manner of Death 28c. Injury at 28d. Describe how injury occurred 2 X Accident 5 Pending I walking to bathroom Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify), Suicide 6 Could not be 3 ☐ Suicide 4 ☐ Homicide 28f. Location (Street and Weber or Rural Route Number City or Town, State) 2130 Boteler determined Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier

State Registrar

3

29b. Signature and title of

RICHARD

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

L COUGH

32. Registrar's Signature

PO

32171

130N 328

29d. Date signed (Month, Day, Year)

WALKERSUNIE, MD

12

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. For State Registrar State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ February 27, 2012 7:00 P. M F. Barber Gary Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Frederick I jams ville 5571 Broadmoor Terrace North If Under 1 Year I If Under 24 Hrs 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday, **Funeral Director** 058-32-1692 1 🛛 M 2 🗆 F 06/30/1939 Canada 72 show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits must be notified at Director 28a-f 1 🗌 Yes 2 🏝 No Ijamsville MD Frederick 10e. Street and Number 10f. Zip Code ō 10g. Citizen of What Country? Funeral permit. Page 1 and 2 should be filed within 72 hours after death with i Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a USA 21754 5571 Broadmoor Terrace North 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No ural", or iten I Examiner r 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-Race - American Indian. If Yes, specify Cuban, Mexican, Puerto Rican, etc. Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes : 1 ☐ Yes 2 No Specify: Completed 3 Widowed 4 Divorced Year or Dates White Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) or other traumatic event, the Alexander Proudfoot management consultant Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Lymon Ford Barber Margaret Murphy 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5571 Broadmoor Terrace North, Ijamsville, MD 21754 Judith Barber/wife 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Department of H Important: If ite any injury or ot once. cemetery, crematory or other place) 1 Burial 2 X Cremation 3 Removal from State 4 Donation 5 Other (Specify) Stauffer Crematory 03/02/2012 Frederick, MD Signature of Funeral Service Licensee 22. Name and Address of Facility Stauffer Funeral Homes, P.A. 1621 Opossumtown Pike, Frederick, MD 21702 23a Part 1 Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence on Exami attending physician and for use as the burial-transit Due to (or as a consequence of): Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No 1 ☐ Live Birth 2 ☐ Fetal deat 4 ☐ Pregnant at time of death 9 ☐ Unknown Month signed by the at the detached for g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autope performed 2 No within 24 hours after death.

To the Funeral Director: After this certificate I completely filled in by the funeral director, pag 1 Yes 2 No Yes 25. Was case referred to medica Be 26. Place of Death (Check only one) examiner? 1 Yes 2 No Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify, 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 Natural 5 Pending injury 1 Yes 2 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 - Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and **A**tle of certifier 29d. Date signed (Month, Day, Year) of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 06-2011

State Registrar MD

istrar's Signature

32. Red

Eskander

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 2<u>6</u> Physician/ Year 2012 MARGIE ODELL BRIGHAM FEBRUARY 3:42p M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death FREDERICK FREDERICK MEMORIAL HOSPITAL FREDERICK 5. Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) 8. Date of Birth **Funeral** 1 □ M 2 💢 F Months Days Hours Month, Day, Year) 27 Feb 26 1927 Director 85 Yrs Maryland 20-12-3967 Usual Residence of Decedent show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event, the Medical Examiner must be 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 7 No Maryland Frederick Myersville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 3900 Highland Avenue 21773 USA 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 2 X No Black, White, etc. δ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 🕅 No Specify: White Completed 3 X Widowed 4 Divorced Specify: Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Construction Administrator Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Edwin Dice Henley Beatrice Louise McCrossin 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3935 Wistman Lane, Myersville, Maryland 21773 Randy Brigham/son 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place)
Resthaven Mem Gdns 1 XBurial 2 Cremation 3 Reproval from Sta Mar 1 2012 Frederick, Maryland 5 Other (Specify) 4 Donation 504 22. Name and Address of Facility Main Street Ricketts Funeral Home Frederick, MD 23a. Part /. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. nterval Between Onset and Death Immediate Cause (Final Physician/ Edema Tulmonar disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of) attending physician and for use as the burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last To the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Month Year 2 No sate has been signed by the page 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? within 24 hours after dearn.

To the Funeral Director: After this certificate hompleted filled in by the funeral director, pag 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 은 1 🗌 Yes 2 No 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) 27, Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Matural Natural 5 Pending 1 🗌 Yes 2 🗌 No Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examine: The basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 3 🗌 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifier 29c. License number

Registrar
DHMH 17 Rev 7/2009

State

801

TOLL

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Card

31. Date filed (Month, Day, Year)

MAR

MO

32. Registrar's Signature

D43091

2-27-12

House Ave, Rederick, MD 2170/

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Dav 26,200 0845 M Virginia Selby Benson Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death County of Death isbury Rehabi sburg Wilcomico litation &NursingCtr If Under 24 Hrs 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) Funeral 1 □ M 2 🔼 Director 219-44-1635 98 16,1913 Nov. Ocran. Usual Residence of Decedent "natural", or items 23a or 28a-f show edical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD. Wicomico Salisbury 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 200 Civic Ave. 21804 United States 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, 1 Never Married 2 Married Completed by permit. Page 1 and 2 should be filed within 72 hours after a Department of Heath and Mental Hygener. Important: If item 27 is marked other than "natural", or any injuy or other traumatic event, the Medical Examin 1 ☐ Yes If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 KNo Specify: Specify: White 3 ¥Widowed 4 ☐ Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Domestic Engineer 9th Be 18. Mother's Name (First, Middle, Maiden Surname)
Mary Hitzelberger Selby 17. Father's Name (First, Middle, Last) William Selby ၉ 19a Informant's Name/Relationship *(Type Print)* David Benson Son 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5181 Cooper Rd., Eden, Md. 21822 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Beechwood Cemetery 03/02/2012 Princess Anne, Md. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Hinman Funeral Home M00295 11673 Somerset Ave., Princess Anne, Md. 21853 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between stock, or heart failure. List only one caus Onset and Death Immediate Cause (Final Physician roscleron disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Physician/Medical Examiner Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director After this certificate has been almost that the death of the property of the Funeral Director After this certificate has been almost the death. Cause (Disease or iinjury that initiated events resulting in death) Last the burial-transit Due to (or as a consequence of): ate has been signed by the attending physician a page 2 should be detached for use as the burial-Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 L Fetal death 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No 5 Other (specify) Month Day Year g 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy performed' death? Yes 2 1 Yes 2 No To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) examiner? 2 No. Other: 1 Tes 4 Narsing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of injury 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending 1 🗀 Yes 2 🗌 No Investigation Could not be Accident Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 28>6 and address of person who completed cause of death (Item 23a) (Type, Print) 2445 uller

State Registrar 32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. For State Registrar State of Maryland / Department of Health and Mental Hygiene Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 2012 Physician/ Month 30 PM Evelyn Bernice March Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Fort Washington Medical Center Fort Washington Georges Prince If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth 9. Birthplace (State or Foreign Country) PA Social Security Number 6. Sex **Funeral** . Age (In yrs. last birthday) (Month, Day, 2 / 6 / 1 1 □ M 2 🗓 F Days Min. 211-14-7474 Director 88 192 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10b. County 10a, State 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 No Md Prince Georges Fort Washington 10e. Street and Number 10g. Citizen of What Country? Funeral 20744 USA 8511 Vistula Drive 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 X No 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Race - American Indian, Black, White, etc. ģ 1 Never Married 2 Married 1 Yes : Maryland 21215-0036 1 Yes 2 X No Specify: 3 🗌 Widowed 4 🗆 Divorced Completed Specify: Black Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Teacher's Local Government Aide Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Jessie Durham Thomas Harris 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

The Ulashington, Md 20744 19a. Informant's Name/Relationship (Type, Print) 8511 Vistula Dr., Ft. Washington, Md Linda Brown-Bush/Daughter Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place, 1 🔲 Burial 2 💢 Cremation 3 🗆 Removal from State Riverdale, Md. 3/6/2012 4 ☐ Donation 5 ☐ Other (Specify) Riverdale Park 22. Name and Address of Facility Bluford Funeral Service 21. Signature of Funeral Service Licenses Chylle D Blyon MLK Ave., SE, Washington, DC 20020 2019 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician hereso disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions Physician/Medical Examiner cause. Enter Underlying Cause (Disease or linjury that initiated events Dise to for as a nonsequence of To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit Due to (or as a consequence of): resulting in death) Last Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year Pregnant at time of death g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 1 Yes 2 No Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital 1 ☐ Yes 2 ☐ No Certificate: To 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify, 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred injury 1/2 Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one)

State

DHMH 17 Rev 7/2009

Registrar

livingston

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

101

31. Date filed (Month

haus

03-05-2012

Please Type or Print in Black Indelible Ink Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene For State Registrar 887 Certificate of Death Reg. No Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 2012 Foster Bowers March 1:45 P M 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 14103 Zinnia Lane Washington Hagerstown Social Security Number If Under 1 Year I If Under 24 Hrs. 8. Date of Birth 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Days Hours 219-12-1026 1 🕅 M 2 🗆 F 90 Jan. 30, 1922 Pennsylvania Usual Residence of Deceden 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 X No MD Washington Hagerstown 10e. Street and Numbe 10f. Zip Code 10g, Citizen of What Country? 14103 Zinnia Lane 21742 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify. Specify: 3 Widowed 4 Divorced White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b, Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Medical Carpenter 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Foster Russell Bowers Mary Pearl Hockensmith 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Clara M. Bowers/ Spouse 14103 Zinnia Lane, Hagerstown, MD 21742 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State 💢 Burial 2 🗆 Cremation 3 🗆 Removal from State Salem Church Cem. 4 ☐ Donation 5 ☐ Other (Specify) Hagerstown, MD Signature of Funeral Service Licensee 22. Name and Address of Facility Rest Haven Funeral Chapel 1601 Pennsylvania Ave., Hagerstown, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of c shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death disease or condition 5415 resulting in death) Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of resulting in death) Last IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Month Day Year Yes 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death?

Examiner ate has been signed by the attending physician and page 2 should be detached for use as the burial-trar # / |ハンハーの Division of Vital Records, P.O. Box 68760 After this certificate al or Attending Physician: funeral director, eral Director: Ai filled in by the fu Hospital 24 hours

Physician/

Medical

Director

Funeral

þ

Completed

Be

မ

Examiner

Funeral

Director

notified 28a-f

ò

Page 1 and 2 should be filed within 72 hours after death v ment of Health and Mental Hygiene. ant. If item 27 is marked other than "natural", or items ury or other traumatic event, the Medical Examiner mu

Department c Important: If any Injury or once.

Ph sician/

Medical

Examine

Physician/Medical

Completed by

Be မ

Certificate:

Medical

29b. Signature and title of certific

MEMore

Baltimore, Maryland 21215-0036

must be r

with the Maryland

	illation. Di	1 Yes 2 No 3 Probably 4 Unknown				
Mellitus			24a. Was an autopsy performed? 1 □ Yes 2 ▼ No 1 □ Yes 2 □ No			
25. Was case referred to medical examiner?		26. Place of Death (Check	only one)			
1 Yes 2 No	Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatien	t 3 DOA Other: 4 Nursing Hor	me 5 Residence 6 Other (Specify)			
27. Manner of Death 1 Natural 5 Pending 2 Accident Investigatio		28c. Injury at work? M 1 □ Yes 2 □ No	8d. Describe how injury occurred			
3 Suicide 6 Could not be 4 Homicide determined	e 28e. Place of Injury - At home, farm, stre building, etc. (Specify)	eet, factory, office	28f. Location (Street and Number or Rural Route Number, City or Town, State)			
(Check 2 Medical Exam	sician: To the best of my knowledge, death o iner: On the basis of examination and/or invest se Practitioner: To the best of my knowledge,	igation, in my opinion, death occurred at	d due to the cause(s) and manner as stated. the time, date and place, and due to the cause(s) and manner stated ce, and due to the cause(s) and manner as stated.			

9c. License number

DZ3815

W-57

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) und 35

Hagerstown

29d. Date signed (Month. Day, Year)

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Day Brumage Terri Lynn March 2012 5:39 P Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 12 Creek Drive Elkton, MD Cecil 8. Date of Birth
Dec. 3, Year 959 Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days Hours 1 M 2 X Months Maryland 52 Director 217-82-6589 Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits within 72 hours after death with the Maryland Director notified MD Cecil Elkton X□ Yes 2 □ No 10e. Street and Number ö 10f. Zip Code 10g. Citizen of What Country? ura!", or items 23a or Examiner must be Funeral 21921 12 Creek Drive U.S.A. 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces? Black, White, etc. þ 1 Never Married 2 X Married Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 No Specify: "natura!" Completed 3 Widowed 4 Divorced Specify White the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working permit. Page 1 and 2 should be filed within 7: Department of Health and Mential Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Me life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Executive Assistant Education Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ည Homer Junior Gentry Mary Louise (Bennett) Grumbine 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ernest S. Brumage, Jr. 12 Creek Drive, Elkton, MD 21921 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State cemetery, crematory or other place, 4 Donation 5 Other (Specify) Frostburg Memorial Pk 03/14/12 Frostburg, MD 22. Name and Address of Facility Hafer Funeral Service, P.A. Signature of Funeral Service Licensee ohn 58 Frost Ave., Frostburg, MD 23a. Part 1. Enter the disease, or complications that bayed the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one bayes on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed burial-transi Cause (Disease or iinjury that initiated events resulting in death) Last and Due to (or as a consequence of): Physician/Medical 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No Month Year Pregnant at time of death Day signed by the at be detached for Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an page 2 autopsy performed? Yes 2 N death? this certificate 1 🗌 Yes 2 🗆 No 25. Was case referred to medical Division of Vital funeral director, 26. Place of Death (Check only one) Be examiner? Other: 4 \(\sum \) Nursing Home 5 \(\mathbb{X} \) Residence 6 \(\sum \) Other (Specify) 2 No 1 🗌 Yes မ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 7. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred injury 1 X Natural 5 Pending work? Accident Suicide Investigation 2 🗌 No s after deat I Director: completed filled in by the 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Location (Street and Number or Rural Route Number, City or Town, State) determined 24 hours Medical 🛮 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the within 2 only one) 29b. Signature and title of certifie

Registrar

State

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MAR 21

32. Registrar

12-01859 Daniel H. Davis Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Daniel H. Davis	1- For State Registrar		State of Maryla		tificate o		iu ivieri	tai nygiei		j. No.	2 1887	
Physician/ Medical Examine	1. Decedent	t's Name (First, Mid						Mo	te of Death	Day Year	3. Time of Death 1224 hrs	
Medical Examine	Dan.		ey Davis	umber)	- т	4b. City, Town, o	or Location o		rch 5, 20	4c. County of De		
		s Medical Ceti				Hagerstow				Washington		
Funeral Director		O-1667	6. Sex	7. Age (In yrs. Ia 78	st birthday) Yrs	Months Da		A 40 .	ate of Birth	(MM/DD/YYYY) 9. 1934	Birthplace (State or reign Co Merryland	
any	Usual Resid	lence of Decedent	v	10c. City.	Town or Locat	own or Location 10d. Inside City Limit						
*	Maryla	and Wa	shington			Fairpl	av			1 Yes 2 No		
the Maryland or 28a-f sh tified at once	10e. Street	and Number	<u></u>	I		10f. Zip Code	-1		100	g. Citizen of What C	ountry?	
th the 1			Acres Rd				1733			US		
r death with or items 23	11. Marital \$	er Married 2 💢	Married Armed F	2 No	lf Y	is Decedent of H	an, Mexican,			White, etc		
tural", turios	3 Wido		ivorced If Yes, Give Yes or Dates: pecify only highest gra	2 - W-900	'_	Yes 2 X N		kind of work do	ne l	Specify: 16b. Kind of Busines	White ss/Industry	
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at once. To Be Completed by Funeral Director	Elementa	iry/Secondary (0-12			ost of working lif				Util			
15-0036 Hygiene, dother than other than the Medical the Medical Complete than the Medical complete the Medical complete the Medical complete than the Medical complete the Medical complete the Medical complete than the Medical complete the Medical complete the Medical complete the Medical complete the Medical complete the Medical complete the Medical complete the Medical complete the Medical complete the Medical complete the Medical complete the Medical complete the Medical complete		Name (First, Middl	e, Last)						,	aiden Surname)		
2121: ould be fil ould be fil ould be marked s marked itc event, To Be		Elmer Dav	is		T 19h Mailing	Address (Stre	Zola			Bitner er, City or Town, St	ata Zin Coda)	
MD ; d 2 shou lith and l n 27 is 1	Doris	s Davis -			1	,				ay,Maryla		
re, rand freath free free free free free free free fre		d of Disposition	on 3 Removal fi			ition (Name of c		Date		20c. Location - City		
Baltimore, permit. Pages I at Department of Hes Important: If ite	4 Dona	ion 5 Other	8 pecify			Mem. Pa	ark	March 10	72012	Williamsp	ort, Maryland	
Ball permit Depart Impor injury	21. Signatur	e of Funeral Service	e Licensee			5 S CO				lliamenor	21795 t,Maryland	
Physician	23a. Part I.	Enter the disease,	or complications that of	aused the death.							Approximate Interval	
/Medical Examiner	Immediate (List only one caus Cause (Final diseas	se a Complicati	ons of Multipl	e Rib Frac	tures					Between Onset and Death	
		resulting in death)	Due to (or as a	a consequence of):							
ner Ter	Sequentially if any, leadi	y list conditions, ng to immediate or Underlying Caus	Due to (or as a	consequence of):							
ted Insit Examiner	(Disease or events resu	injury that initiated Iting in death) Last	C.	consequence of):							
50, te be executed tysician and burial - transit	d										<u> </u>	
60, te be execut hysician and burial - tra												
387 (rtifica rtifica fing ph as the	IF FEMALE: 23b. Was de past 12	cedent pregnant in months?	tne 1 Live t		2 Fe	tal death 3	Ectopic	pregnancy		23d. Date of deliv Month	ery Day Year	
D. Box (the death ce by the attend toched for use	1 Yes		nknown 9 Unkn		- [] 0.							
Vital Records, P.O. bysician: The law requires that the linis certificate has been signed by a director, page 2 should be detach fo Be Completed by P	?	er significant cond	litions contributing to	o death but not re	sulting in the u	underlying cause	given in Pa				to the cause of death?	
Division of Vital Records, nation Attending Physician: The law require is after death al Director: After this certificate has been sixed in by the funeral director, page 2 should by artification: To Be Completed								24	4a. Was ar autopsy	prior t	autopsy findings available o completion of cause of	
Reco								1[yerform Yes 2		? Yes 2 No	
ital ician: ician: s certif rector, Be (25. Was cas examine	C	Hospital:	Innation 2	ER/Outpatient		Other	(Check only on Nursing Home		esidence 6 Ot		
ing Phys After thi funeral di	1 ✓ Y 27. Manner		28a Date (Month		28b. Time of I		ury at Work	? 28d. D	escribe ho	esidence 6 Otl	ner.	
ion tendin leath tor: A the fu	1 Natu 2 ✓ Acci	3 Pe	nding estigation	2012 ear)	0000 hrs	1	Yes 2	No Subje	ect fell			
Division pital or Attendi toral Director: / filled in by the fi	3 Suid	cide 6 Co	uld not be 28e Plac	e of Injury - At ho	me, farm, stree	et, factory, office	building, etc	or	Town, Sta	ite)	Rural Route Number, City	
Divis Hospital or A 24 hours after Funeral Dire tely filled in b	4 Hon	nicide	Physician: To the be	Residence	e death occur	red at the time	fate and nia			cres Road, Fairpl	-	
Division To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the Medical Certificati	(Check only one)		taminer: On the basis	of examination an								
ع ا ا	29b. Signatu	ge and title of certif		XL			se number			29d Date signed (#	Month, Day, Year)	
	30 Na==	od addraga of	On upo completed	so of death (live	230)		.M.E.			March 6, 2012		
JW-7+11	1	lah Ali, M.D.	on who completed cau Assistant Medic			altimore Str	eet, Balti	more, MD 2	21223			
State Registra		d (Month, Day, Year	9 2012 32. R	egytrar's Signatur	е	-			-			

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 2<u>012</u> Physician/ Mar 15, 0335 Dillsworth Allen Medical arry 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Allegany Co. Health Nur. & Rehab. Ctr. Allegany Cumberland 8. Date of Birth 9. Birthplace (State or Foreign Birthpia. Country) **Funeral** Months Min. Hours Director 219-42-5740 69 Usual Residence of Decedent or 28a-f show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at. 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Cumberland MD Allegany 1 XYes 2 No 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? Funeral 21502 USA 311 Pennsylvania Avenue Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces?
1 ☐ Yes 2 ☐ XNo Black, White, etc. δ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No If Yes Give 3 Widowed 4 Divorced Completed white Year or Dates. 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 12 Construction laborer Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Treda Nice John Dillsworth 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip MD 21502 Constance Dillsworth 311 Pennsylvania Ave. Cumberland wife 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 X Burial 2 Crematidn 3 Removal from State cemetery, crematory or other place) 3/19/2012 Sunset Memorial Park MD 4 Depation 5 Other Specify) Cumberland 22. Name and Address of Facility
Scarpelli Funeral Home, PA 21. Sonature 108 Virginia Avenue: Cumberland, MD 21502 23a. Part 1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition Physician/ Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director. After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit Cause (Disease or iinjury that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: Live Birth 2 Fetal death If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð 1 🗆 Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 2 No မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred (Month, Day, Year) Natural 5 Pending work' 1 🗌 Yes 2 🗌 No Accident Investigation Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) Name and address of person who completed cause of death (Item 28a) (Type, Print) s. 200 Glenn St. Ste. 202 ('umberland, IMD 2150) reration [

Registrar

State

31. Date filed (Month, Day, Year)

1 2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Day Year EVans ela 15:05 2012 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death 4mapellis Arunda len ter Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) Funeral 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Days Hours 217-28-2792 **Director** 1 □ M 2 🕅 F 99 06/20/1912 Maryland Usual Residence of Decedent ms 23a or 28a-f show must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 No Maryland Anne Arundel Annapolis 10e. Street and Numbe 10g. Citizen of What Country? 723 Crisfield Way 21401 U.S.A. items 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Examiner Armed Forces Black, White, etc. ō þ 1 Never Married 2 Married 1 ☐ Yes 2 🙀 No If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🙀 No Specify: permit. Page 1 and 2 should be filed within 72 hours aft Department of Health and Mohald Hyghen and Important: If item 27 is marked other than "natural", any injury or other traumatic event, the Medical Exal Specify: White 3 XWidowed 4 Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Homemaker 8 At Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Caleb W. Jones Charlotte Messick 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 723 Crisfield Way - Annapolis, MD Lisa DeVito (Granddaughter) 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Sunnyridge Mem. Park | 03/03/2012 | Crisfield, MD 22. Name and Address of Facility Bradshaw & Sons Funeral Home n Robert H. Bradshaw, 306 W. Main St.- Crisfield, MD 21817 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Ph_sician/ disease or condition resulting in death) Myo Cardia Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Little Underlying Examine Due to (or as a consequence of) executed Cause (Disease or injury and -trans that initiated events resulting in death) Last Due to (or as a consequence of) attending physician a I for use as the burial-Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death.

Within 24 hours after death.

To the Funeral Directorsth.

completely filled in by the funeral director, page 2 should be detached for use as the burner burners. P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 Fetal death 3 Ectopic pregnancy
Pregnant at time of death 5 Other (specify) in the past 12 months?
1 Yes 2 No Month g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, chanic kidney disease , atrial fibrillation 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed death? Yes 2 No 1 Yes Division of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 Yes Hospital 2 No Other: မှ 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 M Natural 5 Pending Accident Investigation 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 教 MO

State Registrar 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

face Pkny Amapoli

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 🤈 🗅 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ MARCH 10, 2012 PEARL HARRIET ERICKSON 11:37A M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death CHARLOTTE HALL VETS. ST. MARY'S HOME CHARLOTTE HALL Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** (Month, Day, 3 – 1 – 1 1 M 2 1 Hours 095-14-7311 91 Director Usual Residence of Decedent 28a-f shov 10b. County 10a. State "natural", or items 23a or 28a-f sho edical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director MD. CHARLES WALDORF 1 Yes 2X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 15315 WOODVILLE ROAD 20601 U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian. Armed Forces Black, White, etc. þ 1 Never Married 2 Married 1 Yes 2X No If Yes, Give Maryland 21215-0036 1 Yes 2 No Specify. Specify: WHITE 3 Widowed 4 Divorced Completed Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) hould be filed within 72 and Mental Hygiene. NATIONAL INSTITUTE Elementary/Seconday (0-12) College (1-4 or 5+) STENOGRAPHER OF HEALTH 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) HARRY REYNOLDSON AUGUSTA JOHNSON and is m 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health an Important: If item 27 is rank injury or and JAN APEL-DAUGHTER 15315 WOODVILLE RD. WALDORF, MD. 20601 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of Date 1 KBurial 2 Cremation 3 Removal from State ARLINGTON NAT. 3-21-12 CEM. ARLINGTON, VA. 4 Donation 5 Other (Specify) M00479 22. Name and Address of Facilit 21. Signature of Juneral Service Licens RAYMOND FUNERAL SERVICE, P.A. LA PLATA, MARYLAND 20646, P.A. 23a. Part 1. Enter the disease, or complications that caused the death. Do not e shock, or heart failure. List only one cause on each line. the mode of dying, such as cardiac or respiratory arrest. Approximate Interval Between Onset and Death ALZHEINERS Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of): sician and burial-transit Due to (or as a consequence of): resulting in death) Last physician Physician/Medical certificate be Box 68760 as attending IF FEMALE: use 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? ō Month Day Year 9 🗌 Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ of Vital Records, Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy Hospital or Attending Physician: 25. Wa case referred to medical Be 26. Place of Death (Check only one) 1 ☐ Yes 2 ☑ No ည 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No Virthin 24 hours after www.

To the Funeral Director: After washingted filled in by the fur Division Accident Investigation 6 Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifie (Check only one) H0037228 MD MARCH 12, 2012 29449 Char Hall Rel Charlotte Hall nel 29449 Char Hall Rel Charlotte Hall 2063

State

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** 2, 11:55 p^M 2012 March Mary Jean Frye /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Montgomery Rockville Collingswood Nursing & Rehab. If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth (Month, Day,) Sept. 10, 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** Country WV Days 87 Sept. 1924 579-26-0742 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If time 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, "to "Modical Exeminar must be notified at 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 1XYes 2 ☐ No MD Rockville Director Montgomery 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 20850 **IISA** 299 Hurley Avenue Funeral 14. Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates: 2 🔀 No 1 ☐ Never Married 2 ☐ Married White Saltimore, Maryland 21215-0036 1 □Yes 2 No Specify. þ 3 X Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Federal Government Analyst 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Nellie Bavely Salvatore Maiolo 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 6604 Paxton Road, Rockville, MD 20852 Howard Lynn Frye/Son 20c. Location - City or Town, State Date 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State March 6 Silver Spring, MD 4 ☐ Donation 5 ☐ Other (Specify) Gate of Heaven Cemetery 22. Name and Address of Facility
Francis J. Collins Funeral Home Inc.
00 University Blvd. W, Silver Spring, 21. Signature of Funeral Service Licensee MD 20901 23a. Part Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Examiner burial-transit requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of): physician Box 68760. Physician/Medical use as the attending IF FEMALE: yes, outcome of pregnancy
☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month for in the past 12 months? 1 ☐ Yes 2 ☐ No 4 Pregnant at time of death 5 Other (specify) P.O. I the detached 9 Unknown ģ 23e. Did tobacco use contribute to the cause of death? cate has been signed page 2 should be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an certificate has autopsy performe 1 ☐ Yes 2 ☐ No 1 ☐Yes 2 No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 □ Yes 2 Accident completely filled in by the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 006243 30. Name and address of person who completed cause of death (Item 23a) (Type, Print

State Registrar

31. Date filed (Month, Day, Year) MAR 06

Please Type or Brint in Black Indelible Ink Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 2012 March 1, Ann G. Ford 11:15 рм Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death Holy Cross Hospital Silver Spring Montgomery . Social Security Number If Under 1 Year If Under 24 Hrs **Funeral** . Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign 579-48-6697 Days Hours **Director** 1 M 2 F 79 Jan. 11, 1933 Washington, DC 28a-f shov 10a. State 10b. County Page 1 and 2 should be filed within 72 hours after death with the Maryland 10c. City, Town or Location Examiner must be notified at Director 10d. Inside City Limits PG 1 Yes 2 X No MD Montgomery Silver Spring 0 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 3128 Gracefield Road, #520 20904 "natural", or items Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces 1 Never Married 2 Married Black, White, etc. 3 Yes 2 No Baltimore, Maryland 21215-0036 Specify: White 1 Yes 2 No Specify. 3 Divorced If Yes, Give Completed Year or Dates the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: if item 27 is marked other than 'any injury or other traumatic event, the Megany joines. Elementary/Secondary (0-12) College (1-4 or 5+) Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မှ Wade Graninger Anna Volland 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Robert N. Ford/Husband 3128 Gracefield Road, #520, Silver Spring, MD 20904 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State March 5 cemetery, crematory or other place 1 K Burial 2 Cremation 3 Removal from State Fort Lincoln Cemetery 4 Donation 5 Other (Specify) 2012 Brentwood, MD 21. Signature of Funeral Service L Francis J. Collins Funeral Home Inc. 500 University Blvd. W., Silver Spring, MD 20901 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line Interval Between Immediate Cause (Final Onset and Death Physician/ Acute Respiratory Failure disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** Pneumonia Sequentially list conditions Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) B To the Hospital or Attending Physician: The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of): sician a Physician/Medical Division of Vital Records, P.O. Box 68760 attending p IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 Yes 2 No Day Month Year signed by the a d be detached f 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Cerebrovascular Accident, End-Stage Renal Disease Completed 1 ☐ Yes 2 XNo 3 ☐ Probably 4 ☐ Unknown should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s performed Yes 2 After this certificate 1 Yes 2 No director. Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify, 2 X No 욘 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA the funeral 27. Manner of Death Certificate: Date of injury 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 1 Natural (Month, Day, Year) 5 Pending injury 1 Yes 2 No hours after death ☐ Accident ☐ Suicide Investigation 6 Could not be filled in by 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined within 24 hours a Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D D36716 March 2, 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Andrew Kundrat, MD 3110 Gracefield Road, Silver Spring, MD 20904 31. Date filed (Month, Day MAR 0 6 . Registrar's Signature State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ RMELA MARCH 2012 10.15 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death Sanctuary at Holy Cross Burtonsville Montgomery Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign 1 □ M 2 🗶 F Hours 213-40-9594 (Month, Pay, Year) 01 / 22 / 1914 Country) 98 **Director** Yrs. Italu Usual Residence of Decedent 28a-f show 10a. State ms 23a or 28a-f sho must be notified at 10b. County with the Maryland 10c. City, Town or Location **Funeral Director** 10d. Inside City Limits Columbia Maryland Howard 1 🗌 Yes 2 🗶 No 10e. Street and Numbe 10f. Zip Code 10g, Citizen of What Country? 8885 Warm Granite Drive 21045 Italy permit. Page 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hyglene. Important: If Item 27 is marked other than "natural", or items any injury or other traumatic event, the Medical Examiner mu 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Was Decedent Ever Armed Forces?

1 Yes 2 No If Yes, Give Year or Dates. Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify Completed 3 X Widowed 4 Divorced Specify: White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done life. DO NOT use retired) during most of working Elementary/Seconday (0-12) College (1-4 or 5+) Seamstress Alterations Shop 6 Be 17. Father's Name (First, Middle, Last, 18. Mother's Name (First, Middle, Maiden Surname) ပ Rosalina DiNicola Domenico D'Avella 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8885 Warm Granite Drive, Columbia, Maryland 21045 Department of Health Important: If item 27 any injury or other to once. Carmela P. Facchiano/Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 R Other (Specify) Entombment Gate of Heaven Cem. 03/08/2012 | Silver Spring, MD 22. Name and Address of Facility Hines-Rinaldi Funeral Home, Inc 11800 New Hampshire Ave., Silver Spring, MD 20904 Signature of Funeral Service Licensee 1232 1/arke 2da. Part 1. Enter the disease, or complications to t caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause or each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ 116 disease or condition Medical resulting in death) (or as a consequence of) **Examiner** Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): 1 To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): been signed by the attending physician should be detached for use as the burial Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 L Fetal dea Pregnant at time of death 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 month 1 Yes 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ Completed 1 Yes 2 No 3 Probably 4 Unknown Were autopsy findings available 24a. Was an this certificate has ral director, page 2 autopsy prior to completion of death? cause of 1 ∐ Yes 3 No 1 Yes completed filled in by the funeral director, 25. Was case referred to medical Certificate: To Be 26. Place of Death_(Check only one) examiner? Other 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Nursing Home 5 Residence 6 Other (Specify, 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work' 1 🗌 Yes 2 🗆 No Accident Investigation Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 - Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and que to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29c. License number

29d. Date signed (Month, Day, Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifie Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

State Registrar TASNEBM

31. Date filed (Month; Day, Year)

MAR 06 2012

DHMH 17 Rev 7/2009

0158y

Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) Type, Print)

28591

WINGS

MILL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ DALE RAY FERRIL FEB 29 2012 11:44P^M Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** MONTGOMERY CASEY HOUSE HOSPICE ROCKVILLE Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** Age (In yrs. last birthday) Days Min. (Month, Day, Year) Hours 1 ☑ M 2 ☐ F **Director** 499-16-4635 90 Yrs 03/19/1921 OK ms 23a or 28a-f show must be notified at 10d. Inside City Limits 10a, State within 72 hours after death with the Maryland 10b. County 10c. City, Town or Location Director 1 Yes 2 No MD MONTGOMERY POOLESVILLE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20900 WHITES FERRY ROAD 20837 USA ural", or items a 12. Was Decedent Ever in U.S. Armyd Forces?

1 Yes 2 No 19
If Yes, Give 1 9 4 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1942 þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1945 1 Yes 2 No "natural", 3 ☑ Widowed 4 ☐ Divorced Specify: WHITE Completed Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than 'any injury or other traumatic event, the Me any injury or other traumatic event, the Me any injury or other traumatic event, Elementary/Secondary (0-12) College (1-4 or 5+) BUDGET OFFICER DEPT. OF THE NAVY Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည JESSIE HARRY FERRIL GRACE ATKINSIN 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) TERRY FERRIL / DAUGHTER 2611 GADSBY PLACE, ALEXANDRIA, VA 22311 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State Date 1 🗹 Burial 2 🗌 Cremation 3 🗍 Removal from State MONOCÁCY CEMETERY 03/05/2012 BEALLSVILLE, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Signature P.O. BOX 86 V HILTON FUNERAL HOME BARNESVILLE, Approximate 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) PROSTATE CANCER Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) The law requires that the death certificate be executed Cause (Disease or Injury and use as the burial-trar that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ___ for in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death be detached signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? \$ 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Completed should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy performed Yes 2 2 🗌 No 1 Yes or Attending Physician: director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner?
1 \(\subseteq \text{Yes} \) Other: 2 No 4 Nursing Home 5 Residence 6 Other (Specify) HOSPICE ပ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this funeral 27. Man r of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending work s after death. 1 Yes 2 No the Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 🗌 Homicide determined within 24 hours a

To the Funeral C

completely filled To the Hospital Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check only on Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29d. Date signed (Month, Day, Year) R143201 Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

DHMH 17 Rev 06-2011

State

DEBRAH MILLER,

31. Date filed (Month, Day,

CRNP

6001

32. Registrar's Signature

MUNCASTER MILL RD., ROCKVILLE

MD

20855

12-02089 Ronald Farley

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

		- For State Cell	tificate of Death	Reg	g. No.	0000
Physicia		Decedent's Name (First, Middle,Last)		Date of Death Month	Day Year	me of Death
^{#⇔di} cal Exami≀	ner	RONALD E. FARLEY, JR.		March 12, 2	2012	014 hrs
		4a. Facility Name (if not institution, give street and number) Upper Chesapeake Medical Center	4b. City, Town, or Location of Death Bel Air	1	4c. County of Death Harford	
Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. la			(MM/DD/YYYY) 9. Birthplac	
Director		217-98-6072 _{1 M 2 F 29}	Yrs. Months Days Hours Min	04/02/	/1982 Country)	MD
	ļ	Usual Residence of Decedent	Town or Location		10d.	Inside City Limits
fr a			treet			Yes 2 No
Aaryland 28a-f show 1 at once.	ġ,			I 10	g. Citizen of What Country?	
215-0036 be filed within 72 hours after death with the Maryland nial Hygiene. rked other than "natural", or items 23a or 28a-f she est, the Medical Examiner must be notified at once	Director	10e. Street and Number 3206 Copenhaver Road	10f. Zip Code 21154	10	USA	
with the ms 23a be noti	ल	11. Marital Status 12. Was Decedent Ever in U. Armed Forces?	S. 13. Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puerto		14. Race - American Ir White, etc.	ndian, Black,
한 등 타	Fune	1 Never Married 2 Married 1 Yes 2 No 3 Widowed 4 Divorced If Yes, Give Year	1 Yes XX No specify:	, , , , , , , , , , , , , , , , , , , ,	Specify: White	Э
rs afte	<u>a</u>	or Dates: 15. Decedent's Education (Specify only highest grade completed)	16a. Decedent's Usual Occupation (Give kind of		16b. Kind of Business/Industr	ry
2 hou		Elementary/Secondary (0-12) College (1-4 or 5+)	during most of working life. DO NOT use ret	ired)		
21215-0036 uld be filed within 72 hours after Mental Hygiene. marked other than "natural", c event, the Medical Examiner.	Completed	12	Technician		Lawn Care	
5-0 led wi Hygier other		17. Father's Name (First, Middle, Last)		e (First, Middle, M E. Bust		
21 be fill be fill be fill be fill	Be	Ronald E. Farley, Sr.,	19b. Mailing Address (Street and Number or			Code)
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 7 Department of Health and Mental Hygiene. Important: If item 27 is marked other than injury or other traumatic event, the Medical	٩	19a. Informant's Name/Relationship (Type, Print) Ronald E. Farley, Sr. her	3206 Copenhaver R			21154
nore, MD 2 ages 1 and 2 shou nt of Health and N t: If item 27 is n other traumatic	ı		Place of Disposition (Name of cemetery,	Date	20c. Location - City or Town	
MOF Pages ent of nt: If		1 XBurial 2 Cremation 3 Removal from State H 1 4 Donation 5 Other Specify:	gnview Mem.Gdns 3/1	//12	Fallston, I	עואַ
Baltimore, permit. Pages 1 an Department of He Important: If ite	Ì	21. Signaktive of Funeral Service Licensee	22. Name and Address of Facility Harkins Funeral	Home.	Inc. Delta	a. PA
	\Box	23a. Pert I. Enter the disease, or complications that caused the death				proximate Interval
Physician / /Medical		failure. List only one cause on each line. Coronary A	rtery Thrombosis due to	o Athero	sclerotic Be	tween Onset and Death
£xaminer		Immediate Cause (Final disease or condition resulting in death) a. Cardiovascular Due to (or as a consequence of the control		Q.o.		
		Sequentially list conditions, b.				
	iner	if any, leading to immediate cause. Enter Underlying Cause	of):			
sd sit	Examiner	(Disease or injury that initiated events resulting in death) Last	of):			
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit		X UNPENDED X AMENDED # 1 as n	oted,23a,27,per me,g920	6 4-10-1	2 sm	
760, icate be exphysician the burial	Medica	IF FEMALE: 23c. If yes, outcome of preg	nancy		23d. Date of delivery	
687 ertific ding p		23b. Was decedent pregnant in the past 12 months? 1 Live birth Pregnant at time of de	2 Fetal death 3 Ectopic pregn	ancy	Month Day	Year
Box 68 e death certifi the attending ed for use as	Physician	1 Yes 2 No 9 Unknown 9 Unknown	Other (Specify)			
O. E at the d i by the tached		Part II. Other significant conditions contributing to death but not	esulting in the underlying cause given in Part I.		bacco use contribute to the co	
res this signed be de	d by			1	2 No 3 Probably	
rds v requ	Completed			24a. Was a autops	sy prior to comple	tindings available etion of cause of
He lav	E			perform 1 ✓ Yes 2		2 No
ital Recicion: The scertificate rector, page	BeC	25. Was case referred to medical	26. Place of Death (Check			
Vita hysici this c	To B	Tes 2 No		ng Home 5 1		
1 Of ling Pl After funera	딜	27. Manner of Death 1 X Natural 5 Pandino	28b. Time of Injury 28c. Injury at Work?	28d. Describe h	now injury occurred	
SiOr ttend death. ctor:	ă	2 Accident Investigation	nome, farm, street, factory, office building, etc.	29f Location /S	street and Number or Rural Ro	oute Number City
Division of Vital Records, P.O. tall or Attending Physician: The law requires that the start death. The law retector: After this certificate has been signed by led in by the funeral director, page 2 should be detact.	Certification:	Suicide Could not be determined (Specify)	iome, farm, street, factory, office building, etc.	or Town, St		outo (tanibo), only
Division of To the Hospital or Attending Phwithin 24 hours after death. To the Funeral Director: After to completely filled in by the funeral		29a. Certifier 1 Certifying Physician: To the best of my knowled	dge, death occurred at the time, date and place, an	d due to the cause	e(s) and manner as stated.	
o the ithin 2 o the o	Medical	one) 2 Medical Examiner: On the basis of examination a and manner stated.	and/or investigation, in my opinion, death occurred	at the time, date a	and place, and due to the cau	
F 3 F 3	Me	29b. Signature and title of certifier	29c. License number		29d. Date signed (Month, E	Day, Year)
	-	Aflen Bank. Mt	O.C.M.E.		March 13, 2012	
		30. Name and address of person who completed cause of death (Iter	n 23a) iner 900 W. Baltimore Street, Baltim	ore MD 2122	23	
		· ·				
S	tate		bulos			

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Reg. No.2 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 03 20ÏŽ 6:55 A Sharon Virginia Frock Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Carroll Golden Living Center Westminster Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Hours 216-60-8526 Director 1 □ M 2 🗶 F 59 09/19/1952 PA Usual Residence of Decedent 28a-f shov ms 23a or 28a-f shortment must be notified at 10a, State 10b. Count 10d. Inside City Limits 10c. City, Town or Location Director MD Carrol1 Westminster 1 🗆 Yes 2 🔀 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1234 Washington Road 21157 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, an "natural", or ite Medical Examiner Black, White, etc. 1 X Never Married 2 ☐ Married þ 1 ☐ Yes 2 X No Specify: Completed Specify: White 3 Widowed 4 Divorced 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) Give kind of work done during most of working than life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) the and Mental Hygien is marked other t Social Worker State of MD/Social Ser Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) မ Thelma V. Greenholtz Joseph E. Frock injury or other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Malling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) and 2 s Health a Important: If item 27 any injury or other tra 1730 Camargo Drive, Westminster, MD James E. Frock/brother 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State ₹ cemetery, crematory or other plac Carroll Cremation 1 Burial 2 X Cremation 3 Removal from State 03/17/2012 Hampstead, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Faritts Funeral Home and Chapel, P.A M 412 Washington Road, Westminster, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Cause (Disease or injury that initiated events resulting in death) Last burial-trar Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year ed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. signed I 23e. Did tobacco use contribute to the cause of death? þ 1 🗌 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy yes 2 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No ျ 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) To the Hospital or Attending Pr within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral 28b. Time of Certificate: 28c. Injury at Natural 5 Pending work? 1 ☐ Yes 2 ☐ No Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 1 🔏 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check ā 🖂 only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) H0061206 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
TRACIE L. Ryberg D.O. 688-C Poole Rd. Westminster

Registrar
DHMH 17 Rev 06-2011

State

Baltimore, Maryland 21215-0036

Box 68760

P.O.

Records,

Division of Vital

32. Registrar's Sig

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 2012 Physician/ March 5:10 Vivian C. Goodman Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Prince Georges Shanti Home Assisted Living Laurel Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Social Security Number 7. Age (In yrs. last birthday) **Funeral** Hours Min (Month, Day, Year) 373-24-3139 Director 1 M 2 X F 84 03/25/1927 MT Usual Residence of Dec 10d. Inside City Limits 0a. State 10b. County 10c. City, Town or Location the Maryland at Director notified 1 🗆 Yes 2 😾 No 28a-f MD Brookeville Montgomery or 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? must be 23a Funeral with 19101 Old Baltimore Road 20833 United States Page 1 and 2 should be filed within 72 hours after death vant of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or items 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2X No If Yes, Give Year or Dates. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Medical Examiner Black, White, etc. ģ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify. Specify. 3 X Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) the Own Home Homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Cornelia Van Tongeran Cornelius Steketee traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Michael T. Goodman - Son 19101 Old Baltimore Road Brookeville, MD other 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date Department of Important; If it any injury or conce. cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State 03/08/2012 Ardent Crematory Hanover, MD 4 Donation 5 Other (Specify) Signature of Funefal Service 22. Name and Address of Facility Harry H. Witzke's Family FH Inc. 4112 Old Columbia Pike Ellicott City, MD 21043 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician Hypertensive Cardiovascular Disease many years disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions Due to (or as a consequence of) if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Exami attending physician and for use as the burial-transit Due to (or as a consequence of) resulting in death) Last Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 X No Month Day Yeer Pregnant at time of death 5 Other (specify) signed by the at Id be detached for 1 ☐ Yes 2.X 9 ☐ Unknown þ Certificate: To Be Completed this certificate has ral director, page 2

if or Attending Physician: The law requires that the death certificate be is after death.

Director: After this certificate has been signed by the attending physicis Division of Vital Records, P.O. Box 68760 funeral director, the

Part II. Other significant conditions of Debility, Hyp	ontributing to death but not resulting in the underlying cause give erlipidemia	23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4X Unknown									
		24a. Was an autopsy performed? 1 Yes 2 XNo 1 Yes 2 No									
25. Was case referred to medical	26. Place of Death (Check only one)										
examiner? 1 ☐ Yes 2 X No	Hospital: 1	4 Nursing Home 5 Residence 6X Other (Specify) Assisted									
27. Manner of Death 1 XNatural 5 ☐ Pending 2 ☐ Accident Investigatio											
3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	281. Location (Street and Number or Rural Route Number, City or Town, State)									
29a, Certifier 1 X Certifying Phy	sician: To the best of my knowledge, death occurred at the time,	date and place, and due to the cause(s) and manner as stated.									

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

D23181

29d. Date signed (Month, Day, Year)

20707

March 7, 2012

29c. License number

To the within 2

Hospital 24 hours

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

704 Avenue #7-1 Laurel, MD G. Bhojraj, MD <u>Gorman</u>

egistrar's Signature

State Registrar

filled in by

Medical

(Check

only one

29b. Signature and title of certifie

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 0956 AM 2012 Oross ma Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Chase If Under 1 Year 6. Sex 8. Date of Birth 9. Birthplace Social Security Number (State or Foreign **Funeral** (Month, Day, Year) 1**X** M 2 □ F Months Davs Hours Min. Countre a New York 092-01-3542 Director Usual Residence of Decedent Shoulo be and Mental Hygiene.
I amd Mental Hygiene.
I is marked other than "natural", or items 23a or 28a-f shov permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural" any injury or other transmit 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County Director 1 X Yes 2 No Roslyn Estates New York Nassau 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 11576 U.S.A. 41 The Serpentine 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 X Yes 2 No 1941If Yes, Give 1946 Black, White, etc. þ 1 Never Married 2 Married Yes 2 X No Specify: Specify: Completed 3 X Widowed 4 Divorced 1946 rhite Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Clothing Manufacturing Executive Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Lillian Davidson Isidore Grossman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8505 Salem Way, Bethesda, Maryland 20814 Edward Grossman - Son 20b. Place of Disposition (Name of cemetery, crematory or other place, 20a, Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State 03/05/2012 | Glendale, New York Carmel Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Hines-Rinaldi Funeral Home. Inc. 21. Signature of Funeral Service Licenses 11800 New Hampshire Ave., Silver Spring, MD 20904 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause Immediate Cause (Final Pnysician/ atrem. pon disease or condition Medical resulting in death) a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner attending physician and for use as the burial-transit the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months? Month Dav Year Pregnant at time of death Unknown 2 No ed by the a g Unknown After this certificate has been signed by funeral director, page 2 should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🂢 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy 2 **7** No 2 X No Be 25. Was case referred to medica 26. Place of Death (Check only one) Hospital 2 No ျပ 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural injury work? 5 Pending in 24 hours after deam.
The Funeral Director: Aft 2 🗆 No Accident
Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 2012 and address of person who completed cause of death (Item 23a) (Type, Print) (7. utten

DHMH 17 Rev 7/2009

State

Registrar

700

MAR 06

31. Date filed (Month, Day, Year)

ones

Chev

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year RENNIS \mathbf{F} GRAHAM MARCH 2012 2:46p 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death FREDERICK MEMORIAL HOSPITAL FREDERICK FREDERICK °**220°°28**⊻80°°1 °20−88−8011 If Under Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign (Month, Day, 1 ☒ M 2 ☐ F Months Days Hours Min. 79 Virginia Feb. Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No Maryland Frederick Frederick 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2741 C Thurston Road United States 21704 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces? Black, White, etc. 1 Never Married 2 Married If Yes, Give Year or Dates 1 ☐ Yes 2 🖾 No Specify: Specify: White 3 Divorced 4 Divorced Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Montgomery County Elementary/Seconday (0-12) College (1-4 or 5+) 11 Heavy Equipment Operator Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Charles Edgar Graham Mary Mann 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Allene R. Graham / Wife 2741 C Thurston Road, Frederick, MD 21704 20b. Place of Disposition (Name of cemetery, crematory or other place) Resthaven Memorial Gardens 20a. Method of Disposition 20c. Location - City or Town, State March Date 6, 1 🛮 Burial 2 🗆 Cremation 3 🗀 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 2012 Frederick, Maryland 22 Name and Address of Facility Resthaven Funeral Services, Skkot Cody P.A. 9501 Catoctin Mounta<u>in</u> <u>Hwy. Frederick</u>, MD 2 . Part 1 Enter the shock, or heart to se, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death List only one cause on each line Immediate Cause (Final disease or condition resulting in death) preumonia Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or impury that initiated events Due to (or as a consequence of) Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No Pregnant at time of death Month Dav Year 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an

Physician/ Medical Examiner

and

physician a the burial-

the attending phone

signed by the a ld be detached f

peen

certificate has

this (

s after death.

I Director: Af
d in by the fu

ithin 24 hours after the Funeral Dire ompleted filled in b

To the I within 2

page

þ

Completed

Be

မ

Certificate:

Medical

29a. Certifier

Hospital or Attending Physician: The law requires that the death certificate be executed

Division of Vital Records, P.O. Box 68760

Physician/

Medical

Examiner

Funeral

Director

28a-f show

be filed within /2 mountails that Hygiene.

rked other than "natural", or items 23a or 28

rice event, the Medical Examiner must be not

2 should be filed with and Mental Hygier? is marked other t

permit. Page 1 and 2 st Department of Health ar Important: If item 27 is.

other traumatic

Maryland 21215-0036

Baltimore,

notified at

Director

Funeral

þ

Completed

Be

ဂ

Physician/Medical

resulting in death) Last

25. Was case referred to medical

autopsy performed? Yes 2 No 26. Place of Death (Check only one)

24b. Were autopsy findings available prior to completion of cause of death? Yes 2

examiner? 2 **A**No Hospital Other: 1 Tes 1 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 Tresidence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 🗷 Natural 5 Pending work' Accident Investigation 1 🗌 Yes 2 No

3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined

28f. Location (Street and Number or Rural Route Number, City or Town, State) 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and in one as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

MB

擊.

3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29d. Date signed (Month, D. Y. Year) 29b. Signature and title of certifier 29c. License number 170926

30. Name a d address of person who completed cause of death (Item 23a) (Type, Print

Jeffra Vay u. MO 31. Date filed (Month, Day, Year)

32. Registrar's Signature

State Registrar

Division or Vital Records, P.O. Box 68760,
To the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

filed within 72 hours after death with the Maryland

3altimore, Maryland 21215-0036

Certification: To 1 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) one) 29b. Signalute and title of certifier 03/03/2012 30. Name and address of person who completed cause of death (Item 234) (Type, Print) 21851 606 oc. 32 Beni 31. Date filed (Month, Day, Year) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

alinda Isabel (eros	SS State 1- For State Registrar	e of Maryla		artment of ertificate of		d Mental H	_	teg. No. 20	12 0889	
Physici ledical Exami		Darrida Ibab	elle Gro					2. Date of Dea Month March 7,	ath	3. Time of Death 0140 hrs	
		4a. Facility Name (if not institution, Saint Mary's Hospital	give street and num	nber)		4b. City, Town, or Leonardtow			4c. County of St. Mary's		
Funeral Director		213-86-7991	Sex 7	7. Age (In yrs. 47	last birthday) Yrs	If Under 1 Year Months Days		_		9. Birthplace (State or Foreign Country) MD	
t the Maryland Sa or 28a-f show any offfied at once.	Director	Usual Residence of Decedent 10a. State 10b. County MD St. Ma 10e. Street end Number 45999 Great M3		Le	x, Town or Location		53	1	0g. Citizen of What	10d. Inside City Limits 1 X Yes 2 No t Country?	
0036 within 72 hours after death with the Maryland jene. ter than "natural", or items 23s or 28s-f she Meikel Laminer must be notified at once	ted by Funeral	15. Decedent's Education (Specify	1 Yes ed If Yes, Give Year or Dates: only highest grade	ces? 2 No completed)	If You	s Decedent of Hispes, specify Cuban, Yes 2 No 's Usual Occupations of working life.	Mexican, Puerto specify: on (Give kind of w	Rican, etc.)	14. Race - White, of Specify: B	lack	
21215-0036 wild be filed within 72 Mental Hygiene. marked other than 'c event, the Medical	e Completed	Elementary/Secondary (0-12) 12th 17. Father's Name (First, Middle, La Leonard E. Gro	,	(or 5+)	Disa	bled	8.Mother's Name		Maiden Surname)	plicable	
U & E	To Be	19a. Informant's Name/Relationship Sharita Dupres	(Type, Print)	dtr.	19b. Mailing	Address (Street	and Number or R	ural Route Num	nber, City or Town,	State, Zip Code) k, MD 20653	
Baltimore, MD 2 permit. Pages I and 2 shoul Department of Health and Inportant: If item 27 is re		20a. Method of Disposition 1									
Balt permit. Depart Import		21. Signature of Funeral Service Lice	_						onic Fune dorf, MD	eral Home 20601	
Physician /Medical Fxaminer		23a. Part I. Enter the disease, or confailure. List only one cause on Immediate Cause (Final disease or condition resulting in death)	each line. Acquire Due to (or as a co	l Immur	ne Defic				est, shock, or heart	Approximate Interval Between Onset and Death	
	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death). Last	Due to (or es e co	onsequence o	n):						
60, e be executed ysician and burial - transit	edical Ex	d. AMENDED 23a,pt.II,27,per me,g927 5-11-12 sm									
lox 6876 eath certificat eattending ph for use as the	5 I	F FEMALE: 23d. Date of delivery 1 Live birth 2 Fetal death 3 Ectopic pregnancy Month D									
s, P.O. E uires that the d n signed by the Id be detached	<u>a</u>	Part II. Other significant conditions Hypertensive A						23e, Did tol		e to the cause of death? Probably 4 Unknown	
Division of Vital Records, ral or Attending Physician: The law require rs after death. al Director: After this certificate has been siyed in by the funeral director, page 2 should by	e Completed	25. Was case referred to medical				26 Place o	f Death (Check or	24a. Was a autops perform	prior deat	e autopsy findings available to completion of cause of h? Yes 2 No	
of Vita	70 Be	examiner? 1 Yes 2 No 27. Manner of Death	Hospital: 1 Inpa		ER/Outpatient	3 DOA	ther Nursing	Home 5 F	Residence 6 Co	Other:	
Sion C Attending r death. ector: Af	Certification:	1 X Natural 5 Pending Provided	tion (Month, De	ıy,Year)			s 2 No			D. I. D. I. M. I. C.	
Division spital or Atten hours after death meral Director: y filled in by the		3 Suicide 6 Could no determine 29a. Certifier 1 Continue 29a.	(Specify)					or Town, Sta	ate)	r Rural Route Number, City	
To the Ho within 24 h To the Fun	edica	(Check only one) 2 Medical Examine	clan: To the best of r:On the basis of e and manner state	xamination ar	ge, death occurre nd/or investigatio	n, in my opinion, c	leath occurred at	ue to the cause the time, date a	e(s) and manner as and place, and due t	o the cause(s)	
		29b. Signature and title of certifier				29c. License r			29d. Date signed (March 8, 2012		
			nt Medical Ex	aminer 9	00 W. Baltim	ore Street, B	altimore, MD	21223			
Sta Registr	te ar	31. Date filed (Month, Pax Year) 6		trar's Signatu	B. 40	well					

OCME

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 2012 Victor Hajimihalis March :00 6 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Berlin Worcester Berlin Nursing Home If Under 1 Year If Under 24 Hrs. Social Security Number 7. Age (In yrs. last birthday, 8. Date of Birth 9. Birthplace (State or Foreign Months Days Hours 5/8/1945 Washington DC 66 219 48 4588 Yrs Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2X No Berlin Worcester 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21811 USA 14 White Sail Circle 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 X Married ☐ Yes 2**xxx**No If Yes, Give Year or Dates 1 ☐ Yes 2 № No Specify: 3 Widowed 4 Divorced Specify: white 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Self. Entrepreneur 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Louis Hajimihalis Constance Poulis 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 14 White Sail Circle Berlin, MD 21811 JoAnn P. Hajimihalis (wife) 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) 3/9/2012 4 ☐ Donation 5 ☐ Other (Specify) Berlin, MD Evergreen Cemetery 22. Name and Address of Facility The Burbage Funeral Home 108 William St. Berlin, MD 21811 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final a. End Stage Parkinson's resulting in death) Acute Respiratory Failure Requiredially list accommon if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of that initiated events resulting in death) Last Due to (or as a consequence of): 23c. If yes, outcome of pregnancy 1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery Ectopic pregnancy 5 Other (specify) Pregnant at time of death Month Day Unknown 23e. Did tobacco use contribute to the cause of death?

Physician Medical Examiner

Physician/

Medical

10a. State

MD

Examiner

Funeral

Director

show

ò

permit. Page 1 and 2 should be filed within 72 hours after death with the Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or any injury or other traumatic event, the Medical Examiner must be I

Baltimore, Maryland

Hajimihalis,

at

or 28a-f sh notified a

Director

Funeral

b

Completed

Be

2

Examiner

Physician/Medical

Completed by

Be

မြ

Certificate:

29a. Certifier

with the Maryland

as the burial-transi and attending physician been signed by the page 2 should be After this certificate has funeral director, within 24 hours after deatl To the Funeral Director:

the Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760

23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 1 ☐ Yes ≥ L 9 ☐ Unknown

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. Was an autopsy performe Yes 2 X No

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown 24b. Were autopsy findings available prior to completion of cause of

2 No

25. Was case referred to medical examiner? 1 Tes 2 **X**No 27. Manner of Death XNatural 2 Accident
3 Suicide
4 Homicide

28a. Date of injury (Month, Day, Year) 5 Pending Investigation 6 Could not be

Other: 1 Inpatient 2 ER/Outpatient 3 DOA 28b. Time of injury worl

4 XNursing Home 5 Residence 6 Other (Specify) 28c. Injury at 28d. Describe how injury occurred 1 🗌 Yes 2 🗌 No

26. Place of Death (Check only one)

Location (Street and Number or Rural Route Number, City or Town, State) Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

(Cheok 2 Medical Examiner: On the basis of examination and/or investigation only/one) 3 To Certifying Nurse Practioner: To the best of my knowledge, death	n, in my opinion, death occurred at the time, date occurred at the time, date and place, and due to	and place, and due to the cause(s) and manner stated the cause(s) and manner as stated.
	29c. License number	29d. Date signed (Month, Day, Year)
Menne Savan Rus	R 135131	March 6, 2012
30. Name address of person who completed cause of death (Item 23a) (Type, Print) Pennie Savage, CRNP 9715 Health	nway Dr, Berlin, M	D 21811
31. Date filed (Month, Day, Year) 32. Registrar's Signature		

determined

death?

32. Registrar's Signature

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Registrar DHMH 17 Rev 7/2009

State

BA 6

Physic Me Exan

	Please Type or Print in Bla					-		egible.	
	1 - State of Maryland /		ment of H cate of D		ınd Me		giene Reg. No. 2	012	00005
ion/	Decedent's Name (First, Middle, Last)		04.0 0. 2	Jan	2	. Date of Dea	ith _	Van	3. Time of Death
ian/ lical	Joann Horai					ebru		e, 2012	5:52 PM
iner	4a. Facility Name (if not institution, give street and number) Laurel Regional Hospital [5. Social Security Number] [6. Sex] [7. Age (In yrs. last b)		City, Town, or Late	Ire If Under 2		Data (Dist	Pri	nty of Death	Seorge's
al or	261-90-2842 1 □ M 2 F 69 Usual Residence of Decedent 69	Yrs. Mo	onths Days	Hours		Date of Birth (Month, Day arch 9	, 1942	State	lace (State or Foreign iry) n Island, NY
Director	10a. State 10b. County 10c. City, Town 10c. Street and Number 10b. Street and Number 10c. City, Town 10c. Street and Number 10c. Street and Number 10c. City, Town 10c. City,			-					0d. Inside City Limits 1 Yes 2 □ No
la la	700 Constitution Avenue NE	"	0f. Zip Code 20002				0	of What Coun State	*
Funeral	11. Marital Status 12. Was Decedent Ever in U.S.		Decedent of His			y Yes or No-		lace - Americ	
_ ≥	1 X Never Married 2 Married 1 Yes 2 X No		, specify Cubar Yes 2 🛣 No		Puerto Ric	an, etc.)		lack, White, e	
Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+)	Business Inc	nsulting						
To Be	17. Father's Name (First, Middle, Last)	ime)							
	19a. Informant's Name/Relationship (Type, Print)	9b. Mailing Ac	ddress (Street a	nd Number	or Rural R	oute Number,	City or Town	, State, Zip C	ode)
1		Star1	ight, 1	rvine					
	1 ☐ Burial 2 🗶 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	incoln	y or other place Cremato	ry 3	Date / 16/2	2012	Brenty	on - City or To	Maryland
	21. Signature of Funeral Service Licensee MO1102	1	me and Address		-			Manus 1 a	nd 20852
al Examiner	23a. Part 1. Enter the disease, or complications that caused the death. Do shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of the conditions) Due to (or as a consequence of the cause. Enter Underlying Cause (Disease or linjury that initiated events resulting in death) Last		Approximate Interval Between Onset and Death						
Completed by Physician/Medical	JF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown d	Date of delive	ry Day Year						
ed by Pr	Part II. Other significant conditions contributing to death but not resulting	g in the under	lying cause give	en in Part I.		23e. Did tol			e cause of death?
Sompleto						24a. Was a autops perfor 1 Yes		o. Were autop prior to cor death? 1 \(\sum \) Yes	sy findings available appletion of cause of
Be	25. Was case referred to medical examiner?			ce of Death	(Check on		L Jay 110j		
5.	1 Yes 2 No 1 Inpatient 2 ER/C	Outpatient 3 Time of	DOA Other	4 L Nurs				ther (Specify)	
icate	1 X Natural 5 Pending (Month, Day, Year) 2 Accident Investigation	injury N	work?			I. Describe ho	w injury occi	irred	
27. Manuar of Death 1 Natural 2 Accident 1 Noticide 3 Suicide 4 Homicide 4 Homicide 28a. Date of injury (Month, Day, Year) 28b. Time of injury M 28b. Injury at work? 1 Yes 2 No 28c. Injury at work? 1 Yes 2 No 28d. Describe how injury occurred									
Medica	29a. Certifier (Check 2 Medical Examiner: On the best of my knowledge only one) 3 Certifying Nurse Practioner: To the best of my knowledge	or investigation	on, in my opinior	, death occu	urred at the	time, date an	d place, and	due to the cau	se(s) and manner stated.
	29b. Signature and title of certifier		29c. License	number 2899	10	2	- 1	ned (Month, E	0 10
	30. Name and address of person who completed cause of death (Item 23a)	(Type, Print)	Lane,				tebr	udry MD	21, 2012
ate	Pritam S, Saini, MD 9101 Ch 31. Date filed (Month, Day, Year) 32. Registrar's Signature	erry	Lane,	<u> </u>	211	L La	urel,	لداما	20.108
rar	MAR 0 6 2012 Senera B. A	College	A						

ID

State Registrar

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760

			Pleas	se Type or Pr			ndelible In l artment of I		-		Legible	2.0	
		For State Registrar		State of N	naryiari		artificate of l		-	Reg. No.	2012	08896	
Physicia	m/	1. Decedent's Name	e (First, Middle, I	_ast)					2. Date of De	ath	Van	3. Time of Death	
Medic	al	Clifford							March	2, 20	12 Year	10:50a [™]	
Examin	er			ive street and number)				r Location of Death	n		County of Dea		
Funeral		12 Foxwo 5. Social Security Nu	ood Cour		ge (in yrs. la	ast birthday)	German If Under 1 Year		8. Date of Bir	th	ntgome:	ry rthplace (State or Foreign	
Director		152-48-0	0834	1 X M 2 □ F		6 Yrs.	Months Days	Hours Min.	May 25	Year)	55	New Jersey	
nd how at	ក	Usual Residence of 10a. State	Decedent 10b. County		10c. Cit	y, Town or Lo	cation			10d. Inside City Limits			
Aaryla 8a-f s tified	Director	Maryland	Montgo	merv	Ger	mantov	n.			1 ☐ Yes 2 🌠 No			
a or 2 be no		10e. Street and Num		•	•		10f. Zip Code			10g. Citiz	en of What C	ountry?	
th with ms 23 must	ed by Funeral	12 Foxwo	od Cour	7			2087			Uni	ted St	ates	
r deal or iter niner		 Marital Status Never Marri 	ied 2 🕅 Marria	12. Was Decedent	?		Was Decedent of H If Yes, specify Cuba	lispanic Origin? (Sp an, Mexican, Puert	pecify Yes or No- p Rican, etc.)	1	 Race - Ame Black, White 		
permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Department of Health and Mental Hyglene. Important: I fire AZ is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		3 Widowed		1 X Yes 2 If Yes, Give Year or Dates.	[™] 1977 198	2	1 ☐ Yes 2🛣 No	Specify:		s	Specify: W	hite	
2 hou "natu edical	plet	(Spec	15. Decedent's cify only highest	s Education grade completed)		16a. Dece	dent's Usual Occup		kina	16b. Kin	d of Business	Industry	
ithin 7 ene. r than	Completed	Elementary/Seco	onday (0-12)	College (1-4 or 5+	5+)	life. D	ONOT use retired) crical En	_	_	Defe	nse Coi	ntracting	
iled w I Hygi other ent, i	Be	17. Father's Name (F	First, Middle, Las			HICC	JIICUI BII	18. Mother's Nar				are to the	
d be f Menta arked atic ev	욘	Russell	B. Harr	is, Jr.				Dori	s Horner	:			
shoul and I		19a. Informant's Na		,		1	ng Address (Street					ip Code)	
and 2 Health em 2; ther t		Barbara 20a. Method of Disp		is (Spous	_		oxwood Co	urt, Ger				- T Ott-	
age 1 ent of nt: If it y or o		1 🗌 Burial 2 (Removal from Stat	e c	emetery, crer	natory`or other plac	· .	Date		cation - City or		
mit. P partm portal / injur		21. Signature of Fur			Met	22 22	Ltan Crem 2. Name and Addre	ss of Facility D	10/2012 eVol Fur	Alex. eral	Home	, Virginia	
De la la la la la la la la la la la la la		Volta	KX4	4/61			2. Name and Addres 10 East Gaithers	Deer Par	k ₂ 0877e				
		shock, or hear	t failure. List onl	omplications that cause y one call se on each li	ed the death ne.	h. Do not ente	er the mode of dyin	ig, such as cardiac	or respiratory ar	rest,		Approximate Interval Between	
Physician/ Medical		Immediate Cause (F disease or condition resulting in death)		a. Cancer			ain					Onset and Death	
Examiner				Due to (or as	a consequ	ience oi):							
- '20	iner	Sequentially list cor if any, leading to im cause. Enter Under	nditions, imediate Iving	b. Due to (or as	a consequ	ience of):							
executed an and rial(text)	Examiner	Cause (Disease or i that initiated events resulting in death) L	iinjury	c. Due to (or as	a consequ	ience of).							
o .g ⊒	ल	resulting in death) L	_dst	`	a consequ	ience on.							
ficate g phys as the	/ledi			d									
h certi tendin r use	an/l	IF FEMALE: 23b. Was decedent in the past 12 n		23c. If yes, outcome		Ideath 3	☐ Ectopic pregnanc	CV .		23	3d. Date of de	*	
e deat the at thed fo	Completed by Physician/Medic	1 Yes 2 9 Unknown		4 ☐ Pregnant 9 ☐ Unknown		death 5	Other (specify)	- Management A	Month Day Year				
that th ned by e detac	y Ph	Part II. Other signifi	icant conditions	s contributing to death	but not res	ulting in the ι	ınderlying cause giv	ven in Part I.	23e. Did to	obacco us	e contribute to	o the cause of death?	
quires en sigi ould be	ted k								1 🗆	Yes 2	No 3□F	Probably 4X Unknown	
law rei nas be s 2 shc	nple								24a. Was		prior to	rtopsy findings available completion of cause of	
: The cate h				T					1 🗆 Yes	rmed? 2 💢 No	death? 1 ☐ Ye	s 2 No	
sician certif rector	Be c	25. Was case referre examiner? 1 ☐ Yes 2 X		Hospital:			Oth	ace of Death (Chec					
g Physer this eral di	e: To	27. Manner of Death	1	28a. Date of in	ury	28b. Time of	28c. Injun	4 □ Nursing H y at	ome 5X Resid			cify)	
eath. or: Aft he fun	ficat	1 X Natural 2 Accident	5 Pending Investigat		ay, rear)	injury	M 1 🗆	? Yes 2 🗆 No					
or Att	Certificate:	3 ☐ Suicide 4 ☐ Homicide	6 ∐ Could no determine	28e. Place of In	jury - At ho tc. <i>(</i> S <i>p</i> ec <i>ify)</i>		eet, factory, office			(Street and Number or Rural Route Number, own, State)			
spital hours neral I		29a. Certifier 1	X Certifying P	hysician: To the best o	f my knowl	edge, death o	occured at the time	, date and place, a	nd due to the car	use(s) and	manner as st	ated.	
To the Hospital or Attending Physician: The law requires that the death certificate by within 24 hours after death. To the Euneral Director, After this certificate has been signed by the attending physicompleted filled in by the funeral director, page 2 should be detached for use as the because of the completed filled in by the funeral director, page 2 should be detached for use as the because of the complete	Medical	(Check 2	Medical Exa	miner: On the basis of urse Practioner: To the	examination	and/or inves	tigation, in my opinio	on, death occurred a	at the time, date a	nd place, a	and due to the	cause(s) and manner stated.	
S Total		29b. Signature and t	title of certifier	· C			29c. License				signed (Mont		
12		20 Nome and add	poen	o complete d	dooth //	020) 75	D3714	42		Mar	ch 3,2	2012	
				o completed cause of 0. 1355 Pic		, , , , ,		00, Rock	ville, N	1D 20	850		
Stat		31. Date filed (Month	n, Day, Year)	32 Regist									
Registra	ir	MA	R 06 20	112 Clerous		. 190	1000						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician/ 201^{Yea} Ruth Elizabeth Holt March 1:20 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Frederick Northampton Manor Frederick 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) **Funeral** 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Hours 217-28-6644 1 □ M 2 □XF Director 79 July 4, 1932 Maryland 28a-f show 10c. City, Town or Location 10a, State 10d. Inside City Limits notified at Director MD Frederick Frederick 1 X Yes 2 No 10e. Street and Number o 10f. Zip Code 10g. Citizen of What Country? ms 23a or must be n Funeral 438 Terry Court 21701 United States items death 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 14. Race - American Indian, the Medical Examiner Black, White, etc. ō þ 1 Never Married 2 Married 1 Yes 2 No If Yes, Give Year or Dates. Baltimore, Maryland 21215-0036 Page 1 and 2 should be filed within 72 hours after 1 Yes 2 XNo Specify. Specify: White "natural", Completed 3 X Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working al Hygiene. life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Custodian Banking ulth and Mental Hygie 27 is marked other r traumatic event, tt Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Schley Taylor Toms Mary Fogle 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is any injury or other trau Leslie Holt III 423 Terry Ct., Frederick, MD 21701 (Son) 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 XBurial 2 Cremation 3 Removal from State Mount Olivet Cem. 3/6/2012 Frederick, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Keeney & Basford P.A. Funeral Home 106 E. Church St., Frederick, MD 2 MO1612 23a. Part 1. Enter the disease, complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate interval Between Congestive heart failure Immediate Cause (Final Onset and Death Ph_sician/ Danja disease or condition Medical resulting in death) Examiner Sequentially list conditions, Examine cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last use as the burial-transit and Due to (or as a consequence of): attending physician Physician/Medical death certificate be Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 X No
9 Unknown Pregnant at time of death 5 Other (specify) Month Day Year signed by the at Id be detached f To the Hospital or Attending Physician: The law requires that the within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the Part II. Other significant conditions contributing to death but not resulting in the underlyIng cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 ☐ Yes 2 🗷 No 3 ☐ Probably 4 ☐ Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed? 1 ☐ Yes 2 ☐ No Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 A Residence 6 A Other (Specify) ၉ 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 IDOA completely filled in by the funeral 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred injury 1 🕅 Natural 5 Pending work?
1 Yes 2 No 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 1 🖳 Certifying Physician: Forthe best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number

Registrar
DHMH 17 Rev 06-2011

State

TOLL

arks

801

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Zoridi

5 201

Saccol

31. Date filed (Month, Day, Year)

MAR 0

MO

32. Registrar's Signature

D43091

3-2-12

House Ave, Frederick, MD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ MARTE COLETTE HAROLD February 11:09 PM Medical 4a. Facility Name (if not institution, give street and number) 4b. City Town, or Location of Death **Examiner** 4c. County of Death Frederick Memorial Hospital Frederick Frederick Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 6. Sex 7. Age (In vrs. last birthday 8 Date of Birth **Funeral** e or Day,) ^{Year)} 9<u>26</u> 1 □ M 2 🛛 F Months Days Hours Min **Director** 85 Pennsylvania 207-18-5909 Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10a. State 10c. City. Town or Location 10d. Inside City Limits Director 1 X Yes 2 □ No PA Mercer Stoneboro 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 2 Buckingham Drive 16153 U.S.A. death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married 72 hours after Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: White "natural", 3 Midowed 4 □ Divorced Specify. Completed Year or Dates other traumatic event, the Medical 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Clerical Insurance Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Arthur F. Lowrie Catherine Ubinger 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) .s permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau Andrew Harold / Son 241 Griffin Road, Stoneboro, PA 16153 20a. Method of Disposition
1 A Burial 2 Cremation 3 Removal from State 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 4 Donation 5 Other (Specify) Christ Our Redeemer 03/05/2012 Pittsburgh, PA Robert E. Dailey & Son Funeral Homes, 1201 North Market St., Frederick, MD 21. Signature of Funeral Service 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one Interval Between Immediate Cause (Final Onset and Death EREBRAL Physician. VASCULAR ACCIDENT disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner HYPOTENSION hours Sequentially list conditions if any leading to immedia cause. Enter Underlying Cause (Disease or iinjury that initiated events Exami Hospital or Attending Physician: The law requires that the death certificate be executed Bradycardia Minutes Due to (or as a consequence of): resulting in death) Last burialphysician s the burial Physician/Medical Division of Vital Records, P.O. Box 68760 ası IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death nse 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ į Day Year Pregnant at time of death 9 Unknown 9 Unknown signed by to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🗹 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an Jas page performed? Yes 2 No this certificate! 2 🗆 No 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: Other: 1 🗌 Yes 2 🗹 No ျပ 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify, 28a. Date of injury (Month, Day, Year) After thi funeral 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Matural 5 Pending work? 1 ☐ Yes 2 ☐ No ithin 24 hours after death.

the Funeral Director: After properties of the further of the further than the f ☐ Accident Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical ☐ Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

Registrar DHMH 17 Rev 7/2009

State

10 P

29b. Signature and title of certifie

CAROL

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

WALDMANN MD

5

W 7TH

400

32. Registrar's Signature

29c. License number D71319

smeet Frederick

March,

21701

2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year ELLEN JANE HALL 21:14 M 2012 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death. REGIONAL NPOICUL 34413641. HIBOMICO If Under 1 Year | If Under 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Days Hours 212-80-3479 71 1 🗆 M 2 🗶 F Jan.7,1941 Maryland Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2X No Crisfield Maryland Somerset 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 3058 William Maddox Road 21817 USA 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces? 1 Yes 2 No Black, White, etc 1 Never Married 2 Married If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: White 3 ☑ Widowed 4 ☐ Divorced Specify 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Hospital Cook 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, William Justice Sally Mae Howard 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21817 Ronald Hall (Son) 3058 William Maddox Road - Crisfield, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 3/4/2012 Rehobeth, MD Rehobeth Baptist Si AFuneral Service Licensee Mary Beth Br 22. Name and Address of Facility BRADSHAW & SONS FUNERAL HM. Bradshaw-Prui 306 W. .-Crisfield. Main 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) that initiated events Due to (or as a consequence of): resulting in death) Last 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ Dav Year Pregnant at time of death g Unknown 23e. Did tobacco use contribute to the cause of death?

Physician Medical Examiner Examine

Physician/

Medical

10a. State

Examiner

Funeral

Director

28a-f show

Ь

ō

"natural",

and Mental Hygiene.

Department of Health Important: If item 27

injury or

any in

Page 1 and 2 should ment of Health and Me

with 1 items 23a

hours after death

Baltimore, Maryland 21215-0036

notified at

the Medical Examiner must be

Director

Funeral

þ

Completed

Be

မှ

and the burial-trai attending physician as use jo be detached the signed by has page 2 Director, After this certificate funeral director, filled in by

or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760

Physician/Medical

3

Completed

Certificate: To Be

Medical

Signature and title of certific

31. Date filed (Month.

IF FEMALE: 23b. Was decedent pregnant in the past 12 month g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Donknown 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of death? 1 Yes 2 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 \square Nursing Home 5 \square Residence 6 \square Other (Specify) 27. Mann of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending injury 1 ☐ Yes 2 ☐ No Accident Investigation Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined 4 Homicide City or Town, State) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one)

29d. Date signed (Month, Day, Year)

within 24 hours a

Hospital

Registrar

State

eted cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 03 Physician/ 12 11:56AM Edna m Haines Medical 4a. Facility Name (if not institution, give street and number, . City, Town, or Location of Death Maugansville 4c. County of Death WASHINGTON Examiner 13914 Villiage Mill Drive 7. Age (In yrs. last birthday) 86 If Under 1 Year If Under 24 Hrs. . Social Security Number 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 3-Month P3 26 212-24-5556 CMT5(V) **Director** 1 □ M 2 X F 28a-f shov 10a. State 10c. City, Town or Location 10d. Inside City Limits Director Washington Maugansville MD ms 23a or 28a-f s must be notified 1 X Yes 2 No 13914 Village Mill Drive 10f. Zip Code 21767 10g. Citizen of What Country? Funeral U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Department of Health and Mental Hygiene. Important: If item 27 is marked other than "... any injury or other traumax." Medical Examiner Black, White, etc. ģ 1 Never Married 2X Married white If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify. Specify: Completed 3 Widowed 4 Divorced Decedent's Education 16a. Decedent's Usual Occupation 16b, Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working fe. DO NOT use retired) residence Elementary/Secondary (0-12) 11th grade College (1-4 or 5+) Homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, ပ္ John E. Younker A. Shoemaker Agnes 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 13914 Village Mill Dr. Maugansville MD Brady F. Haines husband 21767 20c. Location - City or Town, State Clear Spring, MD 20a. Method of Disposition 20b. Place of Disposition (Name of 3-9-2012 1 X Burial 2 Cremation 3 Removal from State cemetery, crematory or other place)
Little Rose Hill 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License ²² Name and Address of Facility
Donald Edwin Thompson Funeral Home, Inc Caitlin O.BOX 310 Clear Spring, MD complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, nly one cause on each line. 23a. Part 1. Enter the disease Approximate Interval Between shock, or heart failure. List Immediate Cause (Final Onset and Death Ph_sician/ Obstruc honic disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Se uentially list conditions if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) burial-transi Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Physician/Medical b Hospital or Attending Physician: The law requires that the death certificate be to 24 hours after death.
Funeral Director: After this certificate has been signed by the attending physicial P.O. Box 68760 use as the IF FFMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No 5 Other (specify) Month Day Year Pregnant at time of death signed by the at Id be detached for Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ò nodu Division of Vital Records, Julmonain 1 Nes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy director, page 2 HnxI 2 🗆 No 1 Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Presidence 6 Other (Specify) 1 Yes 2 No ည 1 Inpatient 2 ER/Outpatient 3 DOA funeral of 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work?
1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred Natural 5 Pending injury Accident Investigation completely filled in by the 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 To the only one) 29b. Signature and title of ce 29c. License number 29d, Date signed (Month, Day, Year) MO 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Medical Campus Rd. Ste 107 Hag.mD 21742 11110 31. Date filed (Mo

State Registrar gistrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend 29d per med cert 6925. 3721/12 lake of Maryland / Department of Health and Mental Hygiene Certificate of Death Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Violet Blanche Hildebrand 2:30 A^M February 2012 Medical Examiner 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Williamsport Nursing Home Williamsport Washington 8. Date of Birth (Month, Day, Year) Nov 13, 1 Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 🗆 M 2 🕱 F Months Days Hours Country) 212-14-7819 Director 95 Maruland Usual Residence of Decedent 27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 10a. State 10b. County filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d, Inside City Limits Director 1 Yes 2 X No Maryland Washington Hagerstown 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? Funeral 387 Key Circle 21740 U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces Black White etc. 9 1 Never Married 2 Married Yes 2 X No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Specify: 3 X Widowed 4 □ Divorced White Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Mental 2 pe Charles Oland Hurd Bessie Lloyd 1 and 2 should by Health and Meritem 27 is mark 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Rickie Hildebrand (Son) 5401 E. 30th St. Apt1 Anchorage, AK 99508 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Page 1 a
Department of H
Important: If ite
any injury or ott Date February 25, 2012 1 Burial 2 K Cremation 3 Removal from State Smithsburg, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Smithsburg Crematory 21. Signature of Funeral Service Licensee MO1414 22. Name and Address of Facility J.L. Davis Funeral Home 12525 Bradbury Ave. Smithsburg, Maryland 21783 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition Onset and Death Physician/ Medical resulting in death) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events resulting in death) Last Examine a consequence of) attending physician and for use as the burial-transit executed Due to (or as a consequence of): Physician/Medical the Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) Live Birth 2 Fetal death in the past 12 months?

1 Yes 2 No Pregnant at time of death Month Day Year the detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown 1 🗌 Yes Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy performe death? within 24 hours after death.

To the Funeral Director: After this certificate Yes 2 No 1 Yes 2 No director, To Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) filled in by the funeral 27. Manner of Death 28a. Date of injury Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural (Month, Day, Year) 5 Pending 1 ☐ Yes 2 ☐ No Investigation Could not be Accident Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 🗌 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title To t 29d. Date signed (Month. Day, Year) March 19, 2012 Name and addres of death (Item 23a) (Type, Print 154 1 31. Date filed (Month, Day, Year) State MAR 2 Registrar

3

CR

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		-	For State	State of	Maryland		artment of F tificate of D		and M			2012	2 08902
			Registrar 1. Decedent's Name (First, Middle, i	Last)		007	tineate or E	Journ		2. Date of Dea		V	3. Time of Death
	Physicia Medic	al .	Bridget C. Irwin February 27, 201						7, 2012	6:15 am			
	Examin	er	4a. Facility Name (if not institution, g				4b. City, Town, or	tchel		0.0	4c. (County of Deat	e George's
	Funeral	4	Collington 1 5. Social Security Number 6		Age (In yrs. la		If Under 1 Year	If Under	24 Hrs.	8. Date of Birt	h	9. Birl	hplace (State or Foreign
	Director		122-26-4123	1 □ M 2 K F	90	0 Yrs.	Months Days	Hours	Min.	(Month, Day			Ireland
	ind show at	'n	Usual Residence of Decedent 10a. State 10b. County		10c. City	, Town or Loc	cation			, ,			10d. Inside City Limits
	Maryla 28a-f stified	rect	Maryland Prince	George's			Mi	tchel	lvill	le .			1 ☐ Yes 2 💢 No
	a or 3	alD	10e. Street and Number		,		10f. Zip Code	0070	1		10g. Citiz	zen of What Co	· I
	ath wif	Funeral Director	10450 Lo	tts ford Ro		i. 13. V	Vas Decedent of Hi	2072 spanic Orio		ify Yes or No-	1	4. Race - Ame	S.A.
Q	within 72 hours after death with the Maryland gjene. ser than "natural", or items 23a or 28a-f show t, the Medical Examiner must be notified at.	by F	1 ☐ Never Married 2 ☐ Marrie	Armed Force	es?	l II	Yes, specify Cuba	n, Mexican	i, Puerto R	lican, etc.)		Black, White	e, etc.
215-0036	ours af tural" al Exa	ted	3 X Widowed 4 □ Divorced	If Yes, Give Year or Date	s.								Caucasian
-C[]	vithin 72 houniene. Ir than "natul the Medical	Completed	15. Decedent (Specify only highest	grade completed)	or 5 .)	(Give I	lent's Usual Occup kind of work done o O NOT use retired)		t of workin	g	16b. Kir	nd of Business/	Industry
7 7	within giene. ner tha t, the I		Elementary/Secondary (0-12)	College (1-4	or 5+)		Secreta	ry				Agro	nomy
DUE.	be filed v ental Hyg rked othe ic event,	To Be	17. Father's Name (First, Middle, La.	^{st)} atrick Coi	110.0			18. Mothe	er's Name	(First, Middle,		attery	
Maryland	should be f and Menta is marked raumatic ev		19a. Informant's Name/Relationship		jne	19b. Mailin	ng Address (Street a	and Numbe	er or Rural				o Code)
	01 1 1 1		Jeanne Burke -				binwood						
saltimore,	ge 1 and 2 it of Healt If item 2 or other	ı	20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3	3 ☐ Removal from St	tate Co	emetery, cren	sition (Name of natory or other place			ate		cation - City or	
E	Pag ant		4 Donation 5 Other (Sp	ecify)	Ft.								Maryland
g	permit. Departr Importa any inji		21. Signature of Funeral Service Lic	- 4	101524	! 11	800 New f	Hamps	y Hin hire	es-Kund AveS	ildi ilve	runera r Sprin	l Home, Inc. 19, MD 20904
			23a. Part 1. Enter the disease, or c shock, or heart failure. List on	omplications that cau	used the death								Approximate Interval Between
 .	Physician/	i o	Immediate Cause (Final disease or condition	-		rtery	Disease						Onset and Death 12/2011
أمود	Medical Examiner		resulting in death)	,	as a consequ	,	t Eailuno						12/2011
į.		ner	Sequentially list conditions, if any, reading to immediate cause. Enter Underlying	ons, July to for as a consequence of j.									
	outed and	Examiner	Cause (Disease or injury that initiated events	C	te Myoc		2 Infarct	ion					12/2011
	icate be executed physician and is the burial	cal E	resulting in death) Last	, i	ertensi	,							Greater than 10 Years
2/60	ficate I g phys as the	Aedical		d. 11975	occion								
×	requires that the death certific. been signed by the attending p should be detached for use as	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?		rth 2 🗌 Feta	l death 3 L	Ectopic pregnanc	су			2	23d. Date of de	
ROX	e death the atter	ysic	1 Yes 2 X No 9 Unknown	4 Pregna 9 Unknow	int at time of d wn	death 5∟	Other (specify) _					Month	Day Year
л. О	law requires that the nas been signed by tl e 2 should be detach	by Ph	Part II. Other significant condition	s contributing to dea	th but not res	ulting in the u	nderlying cause giv	ven in Part	I.	23e. Did t	obacco us	se contribute to	the cause of death?
ds,	quires en sigr ould be	ted b	General Anxie	ty Disord	er					1 🗆	Yes 2 X	© No 3□P	robably 4 Unknown
Vital Records,	aw e 2	Completed	History of Tr	ansient I	schemic	2 Attac	cks	_		24a. Was auto	psy	24b. Were au prior to death?	topsy findings available completion of cause of
Ř	sician: The law r certificate has b lirector, page 2 s		25. Was case referred to medical				00.00			1 Yes	ormed? 2 X No		s 2 No
Vita	ysiciar s certii directo	To Be	examiner? 1 Yes 2 No	Hospital:	patient 2 🗆	ER/Outpatier	Oth	ace of Dea er: 4			dence 6	X Other (Spec	Returement
o	ding Physician: n. After this certific funeral director,		27. Manner of Death 1 Natural 5 □ Pending	28a. Date of		28b. Time of injury	28c. Injur	y at	2	8d. Describe l			
Division of	ttendi death stor: A y the fi	Certificate:	2 Accident Investiga 3 Suicide 6 Could no	ot be	f Injury - At ho	me farm str	M 1 □ eet, factory, office	Yes 2		P8f Location (Street and	Number or Ru	ral Route Number,
	pital or Atteno burs after deatt eral Director. filled in by the		4 ☐ Homicide determin		, etc. (Specify		cot, idotory, omoc		,	City or Tov		THURSDON OF THE	, and the state of
	To the Hospital or Attending Physician: The within 24 hours after death. To the Funeral Director: After this certificate Pagorpletely filled in by the funeral director, pagorpletely filled in by the funeral director	Medical	(Check 2 Medical Ex	Physician: To the bestaminer: On the basis	of examination	n and/or invest	tigation, in my opinio	on, death o	ccurred at t	the time, date a	and place,	and due to the	cause(s) and manner stated.
	To the Hosp within 24 hor To the Fune	¥	OOL Cine burn and title of contific	Nurse Practitioner: 1			20a License		ate and plac	ce, and due to		s) and manner a e signed (Mont	
	7 3		Mai G. Us	accept		mo	>	D00	42049	9		March	02, 2012
			30. Name and address of person w	ho completed cause	of death (Item	23a) (Type, F	Print)	iha '	lliana a d	Marol	040	Manie	nd 20772
	Sta	e	Alain Champalou 31. Date filed (Month, Day, Year)	X, M.V.,	14514 (gistrar's Signa <u>t</u>	ure 🔎	reporo Pa	re, l	upper	. marco	υπυ ,	muryka	nu 20112
	Registra		31. Date filed (Month, Day, Year) MAR 0 6 20	112 200	jistrar's Signa	par	Ked.						

Please Type or Print in Black Indelible lpk, Ensure All Copies Are Legible.

Amend 23a per med cert G925 3/21/12 dk

State of Maryland / Department of Health and Mental Hygiene
Amend 4c & 16 per ril G925 3/21/12 dk

Certificate of Death

Reg. No. 2 0 | 2 1 - For State Registrar 08903 1 Decedent's Name (First Middle | ast) 2. Date of Death 3. Time of Death Physician/ MARGARET ACK SON DNNIE 01 2012 0805 AM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death SILVER SPRING HUSPITAL CROSS Montgomery If Under 1 Year If Under 24 Hrs. 8. Date of Birth 5. Social Security Number 6. Sex 1 ☐ M 2 🔀 F 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Hours (Month, Day, Year) 07 - 20 - 1952 MARY LAND 59 Director 200-44-059 Usual Residence of Decedent and Mental Hygiene. is marked other than "natural", or items 23a or 28a-f show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10a, State 10h County 10c. City, Town or Location 10d. Inside City Limits Director CLEAR BROOK 1 Yes 2 No VД FREDERICK 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 22624 620 SA WRIGHT 12. Was Decedent Ever in U.S Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. Armed Forces? Completed by 1 Never Married 2 Married ☐ Yes 2 ☐ No Baltimore, Maryland 21215-0036 1 ☐ Yes 4 If Yes, Give 1 ☐ Yes 2 X No Specify: Specify: WHITE 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 12 Disabled Disabled Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ HENRY FEATHERS, JR ATHERINE MURDOCK 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) DANIE WRIGHT MARY 620 ROAD 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other placel 5 Other (Specify) WINCHESTER, 4 Donation CREMATION SERVICE 21. Signature of Juneral Service Licenses 22. Name and Address of Facility NINCHESTER HOME, VA 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition Physician/ Asthma Medical resulting in death) Due to (or as a consequence of): Examiner Chronic Obstructive Pulmonary Disease Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of): the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events resulting in death) Last and Due to (or as a consequence of) attending physician a for use as the burial-t Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? 1 ☐ Yes 2 ☑ No Day Month Year ed by the a 1 Yes 2 4 signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ğ 1 Yes 2 No 3 Probably 4 V Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy death? performed? Yes 2 No within 24 hours after death.

To the Funeral Director: After this certificate I 1 🗌 Yes 25. Was case referred to medical To Be 26. Place of Death (Check only one) examiner? Hospital 2 No Other: 1 Inpatient 2 1 ER/Outpatient 3 DOA ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 Yes Accident
Suicide Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifie ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

☐ Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier MDelsel 00064624 01-03-2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 143 SUMMER WALK DR., GAITHERSBURG, MD 20878 SANDEEP SHARMA 31. Date filed (Month; Day, Year) State 32. Registrar's Signature WAR 21 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death RAUL Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 03 Physician/ 6:10 am 2012 William Arthur Maloy March Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner Montgomery Bedford Court Nursing Home Silver Spring Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Months Hours Min 91 Director 025-05-2473 1 🗓 M 2 🗆 F July 31, 1920 Massachusetts Usual Residence of Decedent 28a-f show 10d. Inside City Limits 10b. County 10c. City, Town or Location at 10a. State Director ems 23a or 28a-f sh r must be notified a 1 Yes 2 X No Silver Spring Maryland Montgomery 10f. Zip Code 10g. Citizen of What Country? 10e Street and Number Funeral 20901 U.S.A. 6 Franklin Avenue death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Examiner Armed Forces? Black, White, etc. o 1 Never Married 2 X Married by Baltimore, Maryland 21215-0036 within 72 hours after 1 Yes 2 X No Specify. If Yes, Give Year or Dates Specify: White "natural", 3 Widowed 4 Divorced WWII Completed Medical 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working U.S. Government Dept. life. DO NOT use retired) and Mental Hygiene. College (1-4 or 5+) **5**+ Elementary/Secondary (0-12) of Veteran Affairs the Statistician Be traumatic event, 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) 2 William Arthur Maloy Flora E. Sykes 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Department of Health a Important: If item 27 is any injury or other tratonce. 4454 Jorden Lane, Waldorf, Maryland 20601 Timothy Maloy - Son 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of Date Page 1 a Baltimore Crematory of other place)
Baltimore Crematory 03/06/2012
at Loudon Park 1 Burial 2 X Cremation 3 Removal from State Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Hines-Rinalli Funeral Home, Inc. 21. Signature of Funeral Service Licensee 11800 New Hampshire Ave., Silver Spring, MD 20904 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between nset and Death
Year Immediate Cause (Final Physician/ Alzheimer's Disease disease or condition) Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events) Que to for as a consequence on Examine attending physician an for use as the burial-tr Due to (or as a consequence of): resulting in death) Last Physician/Medical IF FEMALE: yes, outcome of pregnancy
Live Birth 2 D Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year 5 Other (specify) Pregnant at time of death detached the 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Atrial Fibrillation 2 ☐ No 3 ☐ Probably 4 🗓 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an Hypertension autopsy perform page 2 death? 1 ☐ Yes 2 ☐ No certificate 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner?
1 Yes 2 XNo Other: 4 X Nursing Home 5 - Residence 6 - Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA ဂ္ After this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of funeral 28d. Describe how injury occurred 28c. Injury at Certificate: work? iniury 5 Pending 1 X Natural

To the Hospital or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760 s after death. filled in by the To the Funeral D

Investigation Accident Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Signature and title of certifie 29d. Date signed (Month, Day, Year) March 05, 2012 D28656 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 15245 Shady Grove Road, Suite 130, Rockville, Maryland 20850 Ravi Passi, M.D.,

State Registrar

DHMH 17 Rev 06-2011

Medical

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death I. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death February 28, 2012 Physician/ George A. Merkel, Sr. 6:48P. Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Annapolis Anne Arundel Anne Arundel Medical Center 9. Birthplace (State or Foreign 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) 8. Date of Birth **Funeral** Sex 1X∏ M 2 □ F Days Hours Delenth 20 at 1 9 4 2 69 Washington, Director 213-40-5990 Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10a. State 10b. County filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director Prince George's Maryland Bowie 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20715 9306 Merkel Farms Road United States 11 Marital Status Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?

1 Yes 2 No
If Yes, Give Black, White, etc 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 1 Yes 2 No Specify. White "natural", 3 Divorced Specify: Completed Year or Dates Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than 'any injury or other traumatic event, the Me any injury or other traumatic event, the Me ones. Elementary/Seconday (0-12) College (1-4 or 5+) Painting/Construction Painter 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Alfred A. Merkel Ruth Virginia Rollins 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9306 Merkel Farms Road Bowie, Maryland 20715 Janet Merkel -wife 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State Fort Lincoln Cemetery 3/3/2012 4 ☐ Donation 5 ☐ Other (Specify) Brentwood, Maryland 21. Signature of Funeral Service Licens Bonald W. Borgwardt Funeral Home, PA 4400 Powder Mill Road Beltsville, Maryland 20705 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ Coronary Artery Disease disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions Examine Due to (or as a consequence of) if any, leading to immediate To the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury that initiated events and Due to (or as a consequence of) resulting in death) Last attending physician for use as the burial Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Dav Year Pregnant at time of death 2 No the should be detached q 🗌 Unknown g Unknown been signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🔀 Unknown Completed 24b. Were autopsy findings available 24a. Was an page 2 s prior to completion of cause of death? performed? Yes 2 N in 24 hours after death.

the Funeral Director: After this certificate Inpleted filled in by the funeral director, page 2 🗓 No 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital 1 ☐ Yes 2 🔀 No Other: 욛 L□ Inpatient 2X ER/Outpatient 3 □ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 1 Natural 28a. Date of injury (Month, Day, Year) 28c. Injury at Certificate: 28b. Time of 28d. Describe how injury occurred 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office 4 Homicide determined within 24 hours after To the Funeral Direct building, etc. (Specify) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifie Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and tile of certifier 29c. License number 29d. Date signed (Month, Day, Year) D44571 March 2, 2012 10 of person who completed cause of death (Item 23a) (Type, Print) M.D. 7901 Maple Avenue Takoma Park, Maryland 20912 James Cokkrell. 31. Date filed (Month, Day, Year) State MAR 0 6 2012 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene - State AMEND#10e+19 operINF, 3/12/12; BW, McCocertificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Myra Pauline McLoughlin 9:56 March 2012 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Byron House Potomac Montgomery Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday **Funeral** Months Days Hours (Month, Day, Year) 013-22-7921 1 □ M 2 🏲 F 81 **Director** Yrs June 17, 1930 MA Usual Residence of Deced 10c. City, Town or Location 10d. Inside City Limits with the Maryland Director notified 28a-f 1 Yes 2X No Montgomery Potomac 10e. Street and Number Stuart 10f. Zip Code ō 10g. Citizen of What Country? ms 23a or must be r Funeral 8409 Jeb Stewart Road 20854 USA Page 1 and 2 should be filed within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian. Armed Forces? Black, White, etc. by 1X Never Married 2 Married Specify: White Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. "natural", Completed 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working event, the Me life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Elementary Education Teacher Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) of Health and Mental H item 27 is marked ot other traumatic ever 27 is marked or traumatic even မ Patrick McLoughlin Margaret Theresa Hickey 19b. Mailing Address Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 8409 Jeb Stewart Road, David M. McLoughlin/Nephew Potomac, MD 20854 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State o = 5 1 Burial 2XXCremation 3 Removal from State March 5 2012 permit. Page Department of Important: If any injury or Metropolitan Crematory Alexandria, VA 4 Donation 5 Other (Specify) Francis J. Collins Funeral Home Inc. 500 University Blvd. W., Silver Spring, MD 20901 23a. Part 1, Enter the disease, complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ disease or condition resulting in death) Colon Cancer vears Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Exami Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last and Due to (or as a consequence of) physician buri Physician/Medical Division of Vital Records, P.O. Box 68760 the use as ding IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 Li Fetal Gea Pregnant at time of death 3 Ectopic pregnancy 5 Other (specify) in the past 12 months? Month Day Year 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 Tes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an page 2 autopsy performed? death? certificate Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) Assisted Living Hospital 1 ☐ Yes 2 🗷 No ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 🛚 Natural injury work? 1 ☐ Yes 2 ☐ No 5 Pending after death. Accident Investigation the 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, pletely filled in by 4 - Homicide determined City or Town, State) 24 hours Medical 🖺 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check hin the only one) 3 29b. Signature and title of ce 29c. License number 29d. Date signed (Month. Day, Year)

Registrar

DHMH 17 Rev 06-2011

0

State

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Barry Rosenbaum,

6 2012

31. Date filed (Month, Day, Year)

D09834

3720 Farragut Avenue, Kensington, MD 20895

March 5, 2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar 08907 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Monir MacNealy a^{M} March 2012 6:30 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Silver Spring Montgomery Bedford Court Nursing Home 5. Social Security Number Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Hours Min (Month, Day, Year) 1 □ M 2 🏲 F 213-40-9345 May 28, 1927 France Usual Residence of Deceden 10b. County 10c. City, Town or Location 10d Inside City Limits 1 Yes 2X No MD Montgomery Silver Spring 10f, Zip Code 10e. Street and Number 10g. Citizen of What Country? 20906 USA 3700 International Drive 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Black, White, White Armed Forces? 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: If Yes, Give Year or Dates Specify. 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (134 or 5+) Accountant Accounting 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Odette Simond Abdol Hedjazi 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4318 Pinetree Road, Rockville, MD 20853 Kim MacNealy/Son 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 🖾 Cremation 3 ☐ Removal from State March 5, Metropolitan Crematory Alexandria, VA 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses F?ልπሮ፤ፄ^ም፡sሮбዊሧins Funeral Home Inc. 500 University Blvd. W., Silver Spring, MD 20901 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between

Physician/ Medical **Examiner**

Physician/

Medical

10a. State

Director

þ

Completed

Be

မ

Examiner

Funeral

Director

28a-f shov

ral", or items 23a or 28a-f sho Examiner must be notified at

"natural",

permit. Page 1 and 2 should be filed within 7: Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Me

the Medical

with the Maryland

death v

Baltimore, Maryland 21215-0036

the Hospital or Attending Physician: The law requires that the death certificate be executed thin 24 hours after death.

the Funeral Director: After this certificate has been signed by the attending physician and impletely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760

	Immediate Cause (Final disease or condition	Cardiopulmonary Arrest					
	resulting in death)	Due to (or as a consequence of): Respiratory Failure					
	Sequentially list conditions, it is a sequentially list conditions cause. Enter Underlying	Due to or as a consequence of:					
	Cause (Disease or injury	Congestive Heart Failure					
í	that initiated events cresulting in death) Last	Due to (or as a consequence of):					
2		Hypertension					
1	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	Sc. If yes, outcome of pregnancy 1	cy 23d. Date of deli				
	Part II. Other significant conditions con	tributing to death but not resulting in the underlying cause given in Part I.		use contribute to the cause of death?			
			24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 □ No			
	25. Was case referred to medical examiner?	26. Place of Death (Check	only one)				
	1 ☐ Yes 2 ☒ No	ospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Ho	me 5 Residence	6 Other (Specify)			
	27. Manner of Death 1 X Natural 5 ☐ Pending 2 ☐ Accident Investigation		28d. Describe how inju				
	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	nd Number or Rural Route Number, e)				
	(Check 2 Medical Examine	isian: To the best of my knowledge, death occurred at the time, date and place, are: On the basis of examination and/or investigation, in my opinion, death occurred at Practitioner: To the best of my knowledge, death occurred at the time, date and old	the time, date and place	e, and due to the cause(s) and manner stated			

D67092

ted cause of death (Item 23a) (Type, Print) 15245 Shady Grove Road, Rockville, MD 20850

29d. Date signed (Month, Day, Year) March 5, 2012

DHMH 17 Rev 06-2011

State

Registrar

within 24 hours a To the Funeral D

29b. Signature and title of certifier

31. Date filed (Month, Day, Year

30. Name and address of person who completed cau Weihan Wang, MD

MAR 06

Registrar's Signature

Please Type or Print in Black Indelible Ink Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2012 08908 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death MAYA RANI MONDAL Physician/ MARCH 2012 9:32 p M PANT Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death FREDERICK FREDERICK FREDERICK MEMORIAL HOSPITAL Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Pay, Aug • 10 **Funeral** Days Hours India 79 **Director** Aug. none Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City, Town or Location notified at 10d. Inside City Limits Director C.G. 1

✓ Yes 2 □ No Bilaspur Bilaspur 10e. Street and Numbe ò 10f. Zip Code 10g. Citizen of What Country? or than "natural", or items 23a or the Medical Examiner must be Funeral Behind BK Sangeet Vidyalaya 495004 India within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married ☐ Yes 2 💢 No Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 🛱 No Specify. Specify: Indian Completed 3 X Widowed 4 ☐ Divorced Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) should be filed and Mental H ၉ Hari Charan Sikder Saudamani Sikder permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any injury or other traumatic. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Kamalendra Mondal / son 1822 Eagle Rock Lane, Frederick, MD 21702 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place Date 20c. Location - City or Town, State 1 Burial 2X Cremation 3 Removal from State South Carroll Crematory 4 ☐ Donation 5 ☐ Other (Specify) Winfield, Maryland . Signature of Funeral Service Licensee 22. Name and Address of Facility Keeney & Basford Funeral Home Jaguela Krei MO1222 106 E. Church Street, Frederick, MD 21701 23a. Part . Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ STROKE DAYS disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Apriea hours Sequentially list conditions, Examiner Due to (or as a consequence or; cause. Enter Underlying Cause (Disease or iinjury that initiated events nours To the Hospital or Attending Physician; The law requires that the death certificate be executed Arythmia -tran Due to (or as a consequence of): resulting in death) Last burialphysician the burial Physician/Medical years Hypertension Division of Vital Records, P.O. Box 68760 attending p for use as t IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 Yes 2 No Day Year Pregnant at time of death ed by the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown as been signal 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy page 2 No Yes 2 No 1 Yes funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital 2 🗹 No Other: |은 1 Yes 1 Inpatient 2 I ER/Outpatient 3 I DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural iniury work? 1 ☐ Yes 2 ☐ No 5 Pending s after death.

I Director: Aff
d in by the fur 2 Accident
3 Suicide Investigation 6 Could not be within 24 hours after de

To the Funeral Directo

completed filled in by th 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number. determined City or Town, State Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title 29c, License number 29d. Date signed (Month, Day, Year) D71319 March 3, 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 400 West # street Frederick MD 21701 Carol Waldmann mo 31. Date filed (Month, Day, Year) 32. Registrar's Signature State MAR

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Martin McBee Daniel Physician/ March Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death Hagerstown, Washington Meritus Medical Center If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 6. Sex 7. Age (*In yr*s. **60** 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 446-50-3557 12-5-1951 Director 1 X M 2 □ F El Reno, OK 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD Washington Hagerstown 1 Yes 2 XNo Street and Number 18124 Clearway Drive 10f. Zip Code 10g. Citizen of What Country? Funeral 21740 U,S.A. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?
1 ☐ Yes 2 X No Black, White, etc. þ 1 Never Married 2X Married 1 Yes Baltimore, Maryland 21215-0036 Specify: white 1 ☐ Yes 2X No Specify: Completed 3 🗆 Widowed 4 🗆 Divorced Year or Dates or other traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life_DO NOT use retired) 15. Decedent's Education trucking company (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) driver 12th grade Be 17. Father's Name (First, Middle, Last)
Malvin Davi 18. Mother's Name (First, Middle, Maiden Surname)
Doris Jean Anderson David McBee 19a. Informant's Name/Relationship (Type, Print) 9b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 18124 Clearway Dr. Hagerstown, MD 21740 permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau Kimberly McBee wife 20a. Method of Disposition 20c. Location - City or Town, State Smithsburg, MD 20b. Place of Disposition (Name of 3-8^{Date}2012 1 ☐ Burial 2 【XCremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Smithsburg Crem 21. Signature of Funeral Service Lice Donald Edwin Thompson Funeral Home, .O.BOX 310 Clear Spring, MD 21722 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ HYDORTENSION disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine sician and burial-transit Cause (Disease or injury that initiated events resulting in death) Last Physician: The law requires that the death certificate be executed NICOTINE Due to (or as a consequence of) Physician/Medical of Vital Records, P.O. Box 68760 nding physiuse as the IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No Pregnant at time of death 1 Yes 2 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ PERLIPIDEMIA 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐ Yes 2 ☐ No Yes funeral director, 25. Was case referred to predical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No မ 1 Inpatient 2 DER/Outpatient 3 IDOA 27, Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred Hospital or Attending 1 Natural 5 Pending injury work?
1 Yes 2 No Division 2 Accident 3 Suicide the Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 28f. Location (Street and Number or Rural Route Number. 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) mro D0066930 3-6-12 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) tagerstown, MD 21742 13424 Pennsyl 110 Vania

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 4 Day Physician/ 2012^{Year} March 7:30 A^{M} Marian Vada Mongold Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death 12703 Spickler Rd. Clear Spring Washington County Social Security Number 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth
(Month, Day, Year)
Jan. 5, 1925 9. Birthplace (State or Foreign **Funeral** 214-36-2113 87 1 □ M 2 🔀 F **Director** Pennsylvania Vrs 28a-f show 10b. County 10c. City, Town or Location 10d. Inside City Limits notified at Director Maryland Washington County Clear Spring 1 ☐ Yes 2X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? items 23a or ner must be n Funeral 12703 Spickler Rd. 21722 U.S.A. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Black White etc. þ 1 Never Married 2 Married ö ☐ Yes 2 X No Saltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: Specify: White Completed 3 X Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) Il Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) the Registered Nurse Private Duty Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) of Health and Mental H fitem 27 is marked ot r other traumatic ever မ Clarence Cyrus Shultz Alice W. Daniels 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Dennis Mongold-son 11042 Hickory School Rd. Williamsport, MD 21795 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State of F. 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Department or Important: If any injury or Cedar Lawn Mem. Park 3-8-2012 Hagerstown, MD 22. Name and Address of Facility Douglas A. Fiery Funeral Home 21 Signature of Funeral Service License 1331 Eastern Blvd. Morth Hagerstown, MD 21742 23a. Part 1. Enter true isease, or complications the caused the caused the contract the mode of dying, such as cardiac or respiratory arrest, shock, or he in failure. List only one can also need to cause the caused the c Onset and Bray Immediate Cause (Final Physician/ In monary Dead 000 disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Esquentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) attending physician and for use as the burial-tran that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE. 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 Yes 2 No
9 Unknown Month Year Pregnant at time of death Unknown Part II. Other significa t conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 18001 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an men Director: After this certificate has autopsy perform Yes the funeral director. 25. Was case referred to medical Be 26. Place of Death (Check only one) 1 ☐ Yes 2 ☑ No Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred work? 1 Natural 5 Pending injury 2 No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) To the Hospital within 24 hours a To the Funeral D Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one 29b. Signature 29d. Dates gned (Month, ath (Item 23a) (Type, Print) 31 Date filed (Month State

DHMH 17 Rev 06-2011

Registrar

12-02048 Jeffrey L. Marmaduke Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene 2012 089

		1- For State Registrar	,	Cert	ificate of	Death			F	Reg. No.		
Physicia Medical Exami	an/	Decedent's Name (First, Midd.		fery Lynı	n Marma	duke			2. Date of Dea Month March 11	ath Day	Year	3. Time of Death 1315 hrs
		4a. Facility Name (if not institution 449 A W. Washington	Street			b. City, Town, Hagersto	wn			- V	County of Dea /ashington	
Funeral Director		5. Social Security Number 213-68-6316	6. Sex	7. Age (In yrs. las		If Under 1 Y		der 24Hrs.	8. Date of Bi		Fore	Birthplace (State or eign ^{Country)} Maryland
Maryland 28a-f show any 2 at once.	tor	Usual Residence of Decedent 10a. State 10b. County Maryland Wa. 10e. Street and Number	shington	10c. City, T	own or Location		rstowi	n		10- Cities	en of What Co	10d. Inside City Limits 1 X Yes 2 No
ith the Maryland 23a or 28a-f sho notified at once.	Director	449 A West	Washingt	on Street	5		21740			iog. Gitiz	U.S.2	
2 hours after death w' "natural", or items	Completed by Funeral	11. Marital Status 1 Never Married 2 M. 3 Widowed 4 Div 15. Decedent's Education (Spe	Armed F 1 Yes orced If Yes, Give Ye or Dates: cify only highest gra	2 X No ar	If Ye	s, specify Cut Yes 2 $oldsymbol{X}$.	oan, Mexicar No specify pation (Give	n, Puerto F	ork done		White, etc.	erican Indian, Black, White s/Industry
036 thin 7 ne.	힏	10				Music	ian				Musi	ic
MD 21215-0036 d 2 should be filed within 7 th and Mental Hygiene. n 27 is marked other than numatic event, the Medica	Be Cor	17. Father's Name (First, Middle, Franklin	Last) T. Marma	duke			18.Mothe		First, Middle, dra L.			
AD 21 2 should h and Me 27 is ma matic ev	٩	19a. Informant's Name/Relations Sandra L. Bowe		ther)	9.	•					y or Town, Sta yland 2	
Baltimore, Permit. Pages 1 and Department of Healt Important: If item injury or other training.		20a. Method of Disposition 1 Burial 2 K Cremation 4 Donation 5 Other St	pecify:	rom State Smit	ace of Disposit ematory or othe hsburg	crema	tory	15,	Date rch 2012	S	mithsbu	or Town, State
Ball permit Depart Impor		21. Signature of Funeral Service	Licensee Dwis	MO 14	14	me and Address						eral Home ryland 21783
Physician Medical		23a. Part I. Enter the disease, or failure. List only one cause Immediate Cause (Final disease	on each line.	caused the death. D			ng, such as o	cardiac or	respiratory am	rest, shoo	ck, or heart	Approximate Interval Between Onset and Death
eonted and transit	al Examiner	or condition resulting in death) Sequentially list conditions, if a.y, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a b. Hepatit Due to (or as a c. Due to (or as a	a consequence of): tis C Inf a consequence of): a consequence of):	ection	and Ch						
Box 68760, c death certificate be executed the attending physician and ed for use as the burial - transit	sician/l	IF FEMALE: 23b. Was decedent pregnant in th past 12 months? 1 Yes 2 No 9 Unk	23c. If yes,	nant at time of deat	ncy 2 Feta			ic pregnan		23d.	. Date of delive Month	ery Day Year
, P.O. E ires that the d signed by the	d by Phy	Part II. Other significant condition Diabetes Mell		o death but not res	ulting in the un	derlying caus	e given in Pa	art I.				to the cause of death? obably 4 🗹 Unknown
aw requi	Completed								24a. Was autop perfo 1 Yes	osy ormed?	prior to death?	
Vital Rec ysiciao: The I his certificate I director, page	Be	25. Was case referred to medical examiner?	(Upanital: -			_	Other	_				
ion of Vi teodiog Physi cath. tor: After this	tion: To	1 Yes 2 No 27. Manner of Death 1 Natural 5 Pend	28a. Date (Month		R/Outpatient	ury 28c. Ir	njury at Work	k? 2	Home 5		ry occurred	er: Scene
Division To the Hospital or Atteodis within 24 hours after death. To the Fuoeral Director: A completely filled in by the fu	Certification:	3 Suicide 6 Could 4 Homicide	d not be mined (Specify)	ce of Injury - At hom	ne, farm, street	factory, office	e building, et	tc. 2	28f. Location (or Town, \$		d Number or F	Rural Route Number, City
Divis To the Bospital or 4 within 24 hours after To the Fuoeral Dire completely filled in b	edical (Control only	nysician: To the beaminer: On the basis and manners	of examination and								
	Me	29b. Signature and title of certifie		5/100			nse number C.M.E.			1.0	ate signed (M ch 12, 2012	fonth, Day, Year)
\$		30. Name and address of person Russell Alexander MD	. Assistant M	/ledical Examir	ner 900 V	V. Baltimoi	re Street,	Baltimo	ore, MD 21	223		
St Regist	ate	31. Date filed (Month, Day, Year) MAR 2 1 20	12 32. R	egistrar's Signature	backer	,						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ P2 March 2012 4:35 P Carol Jean Myers Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Carroll Hospital Center Carroll Westminster Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday **Funeral** 1 □ M 2 🏅 F Days Hours July 30, 1937 74 PA **Director** 172-32-0850 ed other than "natural", or items 23a or 28a-f shov event, the Medical Examiner must be notified at 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits within 72 hours after death with the Maryland Director 1 🗆 Yes 2 😾 No Westminster MD Carroll 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 21158 1804 Old Taneytown Rd. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married 1 ☐ Yes 2 No If Yes, Give Maryland 21215-0036 White 1 ☐ Yes 2X No Specify: Specify: Completed 3 X Widowed 4 □ Divorced Year or Dates 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than 'any injury or other traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) own home Homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Ethel Keller David Gardner 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 630 Hickory Overlook Dr., Belair, MD Mark Fishel - son Baltimore, 20a. Method of Disposition 20c. Location - City or Town, State 20b. Place of Disposition (Name of Date cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 03/14/2012 | Hampstead, MD 22. Name and Address of Francists Funeral Home and Chapel, P.A. Jali 21157 412 Washington Road, Westminster, MD Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each limit. Immediate Cause (Final Onset and Death ∜nysician/ nal disease or condition Medical resulting in death) r as a consequence of **Examiner** Sequentially list conditions Examiner Due to (or as a consequence or). if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury To the Hospital or Attending Physician: The law requires that the death certificate be executed use as the burial-transit and that initiated events Due to (or as a consequence of) resulting in death) Last signed by the attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 Yes 2 No for Year should be detached 1 ☐ res ∠ ☐ 9 ☐ Unknown q Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☑ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy performed certificate has 1 🗌 Yes 2 🗌 No Yes 2 within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, I 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital: Other: Certificate: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify, 27. Manne T Death 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) 5 Pending Natural 1 Yes 2 No 2 Accident Investigation 3 Sulcide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) WESTMINSTER MD 2157 876 WASHINGTON RI) ERNESTO MENDOZA Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death March 4, Physician/ D2012 7:35A. Esther Nelson Gwendolyn Medical 4a. Facility Name (if not institution, give street and number) 3160 Gracefield Road, RC1527 4b. City, Town, or Location of Death **Examiner** Prince George's Silver Spring 7. Age (In yrs. last birthday) 97 yrs. If Under 1 Year If Under 24 Hrs. Social Security Number 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days Hours Months 1 □ M 2 😾 F Feb. 22, 1915 Michigan 578-36-3143 Director Usual Residence of Decedent er than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits filed within 72 hours after death with the Maryland Director 1 🗆 Yes 2 🔀 No Silver Spring Maryland Prince George's 10f. Zip Code 10g. Citizen of What Country? Funeral 20904 United States 3160 Gracefield Road, RC1527 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian. Armed Forces?

1 Yes 2 No Black, White, etc þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2X No Specify: If Yes, Give 3 X Widowed 4 ☐ Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) . Page 1 and 2 should be filed within 72 ment of Health and Mental Hygiene. tant: If item 27 is marked other than iury or other traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) Retail/Grocery Bookkeeper Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Esther Schrontz James Merle Ewing 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 11815 Rivershore Drive Dunkirk, Maryland 20754 19a. Informant's Name/Relationship (Type, Print) Merle Nelson -son 20a. Method of Disposition
1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1 a
Department of H
Important: If ite
any injury or ot Fort Lincoln Cemetery 3/10/2012 Brentwood, Maryland 4 Donation 5 Other (Specify) Signature of Funeral Service License Dônardov: Borgwardt Funeral Home, 4400 Powder Mill Road Beltsville, Maryland 20705 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final nysician/ Pneumonia disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** Urinary Tract Infection Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine Due to (or as a consequence of): burial trapsit Alzheimer's Disease or Attending Physician: The law requires that the death certificate be executed the attending physician and the for use as the burial-trap Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy After this certificate has been signed by the atter funeral director, page 2 should be detached for u in the past 12 months? Month Day Year Pregnant at time of death 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 X No 3 ☐ Probably 4 ☐ Unknown Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yes 2 No 2 XNo 1 Yes Be (25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: Certificate: To 1 ☐ Yes 2 💢 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 X Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred To the Funeral Director, After Gompleted filled in by the funer (Month, Day, Year) injury 1 X Natural 5 Pending work? 1 ☐ Yes 2 ☐ No M Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Hospital within 24 hours a Medical 29a. Certifier 1\Delta Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) March 5, 2012

State Registrar

mane MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Loveen J. Puthumana,

MAR 06 2012

31. Date filed (Month, Day, Year)

1059524

M.D. 3110 Gracefield Road Silver Spring, Maryland 20904

12-01815 John Nuzzo Amend 21 per FH G925 3/27/12 dk
Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

John Nuzzo		Sil- For State Registrar	tate of Maryla		artment o		d Mental H		eg. No. 201	2 0891
Physician Medical Examin	n/	1. Decedent's Name (First, Midd John Perri Nu						2. Date of Dea Month March 3,	ath	3. Time of Death 1620 hrs
		4a. Facility Name (if not institution 42 East Washington		imber)		4b. City, Town, or Hagerstown		th	4c. County of Deat Washington	h
Funeral Director		5. Social Security Number 562-82-2215	6. Sex	7. Age (In yrs.	last birthday) 61 Yrs	If Under 1 Year Months Days			rth (MM/DD/YYYY) 9. 8i Forei	
any	- 1-	Usual Residence of Decedent 10a. State 10b. County			y, Town or Locat	1 1		111/14/	/1731 Fe	10d. Inside City Limits
	횷	Maryland Wash	ington	Н	agerstov	VII. 10f. Zip Code			10g. Citizen of What Cou	1 X Yes 2 No
th the Maryland 23a or 28a-f sho aotified at once.		42 East Washi				2174	-		U.S.A.	
fler death wi	Fune	11. Marital Status 1 Never Married 2 N 3 Widowed 4 X Di	farried Armed Formation Armed Formation X Yes Vorced If Yes, Give Yee	2 No		is Decedent of His les, specify Cuban Yes 2 X No	, Mexican, Puert	Specify Yes or No to Rican, etc.)	14. Race - Amer White, etc. Specify: Whi	rican Indian, Black,
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygione. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once.	Completed by	15. Decedent's Education (Spe Elementary/Secondary (0-12)			during m	nt's Usual Occupat ost of working life.			16b. Kind of Business	/Industry
21215-0036 uld be filed within 7 Mental Hygiene. marked other than	Be Com	12 17. Father's Name (First, Middle George John			Disa	abled		ne (First, Middle,	NA Maiden Surname) Messick	
MD 21 d 2 should the and Mer an 27 is mar	2	19a. Informant's Name/Relations Jonni Le anne	ship (Type, Print)	ighter		,			mber, City or Town, State	
lore, Nges I and to of Health		20a. Method of Disposition 1 X Burial 2 Crematio	n 3 Removal fro	om State	Place of Dispos crematory or other	ition (Name of cer ner place)	netery,	Date	20c. Location - City or	Town, State
Baltimore, permit. Pages I ar Department of He Important: If ite		4 Donation 5 Other S 21. Signature of Funeral Service	Licensee	Ŋ		lame and Address	of Facility Re		Funeral Cl	
Physician	+	Eric Brown per 23a. Part I. Enter the disease, or failure. List only one cause	r complications that ca	aused the deat					e, Hagerstov rest, shock, or heart	n Md 21742 Approximate Interval 8etween Onset and
/Medical Examiner		Immediate Cause (Final disease or condition resulting in death)	01			sease				Death
	niner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated	b. Due to (or as a	consequence	of):					
cecuted and - transit		events resulting in death) Last	Due to (or as a	consequence	of):					
		UNPENDED IF FEMALE:	AMENDED 23c If yes	outcome of pre	gnancy				23d. Date of deliver	N.
, P.O. Box 68766 res that the death certificate signed by the attending phybe detached for use as the b	cian/	3b. Was decedent pregnant in t past 12 months?	he 1 Live b	irth ant at time of d	2 Fe	tal death 3 [her (Specify)	Ectopic pregr	nancy		y Day Year
P.O. I res that the signed by the be detached	<u>a</u>	Part II. Other significant condi	tions contributing to	death but not	resulting in the u	inderlying cause g	iven in Part I.		obacco use contribute to	
Cords law requi	ompleted								prior to death?	utopsy findings available completion of cause of
Vital Reorginists The his certificate director, page	m	25. Was case referred to medica examiner?	Hospital:	npatient 2	ER/Outpatient		of Death (Check		Residence 6 🗸 Othe	r Scene
sion of Vildeding Physic death. ctor: After this y the funeral dir	tion: To	1 ✓ Yes 2 No 27. Manner of Death 1 ✓ Natural 5 Pen	28a. Date (Month,		28b. Time of I	njury 28c. Injur	y at Work?		how injury occurred	1. Scene
Divisi Hospital or Att 44 hours after de Ruocral Direct tely filled in by	Certification:	3 Suicide 6 Cou	28e. Place ermined (Specify)	e of Injury - At I	nome, farm, stree	et, factory, office b	uilding, etc.	28f. Location (or Town, S	Street and Number or Ro State)	ural Route Number, City
To the Hos within 24 h To the Fuc	<u>ल</u>	(Oncor only		of examination					se(s) and manner as state and place, and due to the	
	Ž	29b. Signature and title of certifi				29c. License O.C.M			29d. Date signed (Mo	nth, Day, Year)
IW let		30. Name and address of person Pamela E. Southall, M) W. Baltimore	e Street, Balt	timore, MD 2	1223	
Sta Registr	te	31. Date filed (Month, Day Year)	8 2012 32 R	gistrar's Signa	ture	new				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 3. Time of Death LAWRENCE DOUGLAS NEVITT Medical MARCH 5:05P ^M 2012 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 31510 POINT LOOKOUT ROAD MECHANICSVILLE ST. MARY'S Social Security Number **Funeral** . Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs
Months Days Hours Min. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign **Director** 214-48-5454 **X**M 2 □ F Country) 61 FEB.8,1951 WASH., DC or 28a-f show notified at 10c. City, Town or Location Director 10d. Inside City Limits MD ST. MARY'S MECHANICSVILLE 1 Yes 2X No 0 10e. Street and Number 10f. Zip Code must be Funeral 10g. Citizen of What Country? 23a 31510 POINT LOOKOUT ROAD 20659 items U. S. A. i "natural", or item edical Examiner i 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Armed Force þ 1 Never Married 2 X Married Maryland 21215-0036 1 Yes 2 You Black, White, etc. 1 Yes 2 No Specify. Completed 3 Widowed 4 Divorced Year or Dates Specify: Medical WHITE 15. Decedent's Education 16a. Decedent's Usual Occupation (Specify only highest grade completed) I Hygiene. 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) the 6 PROFESSIONAL TRUCK DRIVER ALLIED TRAILER Be 17. Father's Name (First, Middle, Last) and Mental H 18. Mother's Name (First, Middle, Maiden Surname) ARTHUR PRESTON NEVITT MARTHA JEANETTE KING 19a. Informant's Name/Relationship (Type, Print) permit. Page 1 and 2 sh Department of Heath an Important: If item 27 is any injury or other trau once, 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) SHARON NEVITT SPOUSE 31510 PT. LOOKOUT RD., MECHANICSVILLE, MD20659 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of MARCT 20c. Location - City or Town, State 1 Burial 2x Cremation 3 Removal from State 4 Donation 5 Other (Specify) METRO.CREMATORY 17, 2012 ALEXANDRIA, 22. Name and Address of Facility RAYMOND FUNL.SERVICE, P.A. 5635 WASHINGTON AVE., LA PLATA, MD 20646 M00641 Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line Interval Between Immediate Cause (Final disease or condition Physician/ Medical resulting in death) (2 minter Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) attending physician for use as the buria Physician/Medical or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 the IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No 3 Ectopic pregnancy Pregnant at time of death 5 Other (specify) 9 Unknown Month 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 23e. Did tobacco use contribute to the cause of death? Completed 1 Yes 2 No 3 Probably 4 Unknown has 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform

director, funeral

Be

မ

Certificate;

Medical

27. Manner of Death

(Check

only one 29b. Signature and to

Natural

Accident

Suicide

Homicide

5 Pending

e of

Investigation

6 Could not be

Yes 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 2 1 No Other: 1 Inpatient 2 ER/Outpatient 3 DOA

5 Residence 6 Other (Specify)

28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 1 Yes

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

28f. Location (Street and Number or Rural Route Number,

W-7 s of person who completed cause of death (Item 23a) (Type, Print)

25500 BINT LOWELT ROAD,

State Registrar ST-MARY'S HOSPITAL

Director

within 24 hours a

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Ruth Lucille Oden Physician/ March 2012 8:12 PM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Frederick Memorial Hospital Frederick Frederick Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** ^{Year)}1927 Months Days Hours Min. Apr. 19 Mary land 219-20-0651 84 **Director** Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Page 1 and 2 should be filed within 72 hours after death with the Maryland must be notified at Director Frederick Maryland Frederick 1 X Yes 2 ☐ No ò 10e. Street and Number 10f. Zip Code Citizen of What Country? 21701 U.S.A. 23a Funeral 113 South Jefferson Street Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces?

1 Yes 2 X No Black, White, etc. o. Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: White 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates "natural" 3 XWidowed 4 ☐ Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than 'amy injury or other traumatic event, the Meonce. Elementary/Seconday (0-12) College (1-4 or 5+) Assembly Worker Manufacturing Be 17. Father's Name (First, Middle, Last) Mother's Name (First, Middle, Maiden Surname) William Christopher Rice Bessie Louise Carmack မ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4202 Lime Kiln Road, Frederick, MD 21703 19a. Informant's Name/Relationship (Type, Print) Randall W. Boone, Jr., son 20a. Method of Disposition
14 Burial 2 □ Cremation 3 □ Removal from State 20b. Place of Disposition (Name of 20c. Location - City or Town, State Mount Olivet Cemetery Mar. 7, 2012 Frederick, MD 21701 4 ☐ Donation 5 ☐ Other (Specify) মিউলিল্প প্রার্থ চিল্লিড় ford PA Funeral Home 106 East Church St., Frederick, MD 21701 21. Signature of Funeral Service Licer M00255 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final RENAL Ph_sician/ MERACIO disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner ISCHEMI C Sequentially list conditions, it any, reading to immediate cause. Enter Underlying Due to (or as a consequence of): Examin ABDOMINAL Cause (Disease or iinjury that initiated events resulting in death) Last the Hospital or Attending Physician: The law requires that the death certificate be executed burial-trar Due to (or as a consequence of) physician the burial Physician/Medical Division of Vital Records, P.O. Box 68760 attending p for use as t IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?

1 Yes 2 No Pregnant at time of death Year 5 Other (specify) Month Day the 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed certificate has been si rector, page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 2 No 1 Yes Yes Be 25. Was case referred to medica 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2X No Inpatient 2 ER/Outpatient 3 DOA ၉ 1 🗌 Yes 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural injury work' 5 Pending 1 🗌 Yes 2 🗌 No thin 24 hours after death.

the Funeral Director: A suppleted filled in by the fu Accident Investigation 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one 29b. Signature/and title of certifier Name and address of person who completed cause of death (Item 23a) (Type, Print) 9 Benne 400 Donald

Registrar

31. Date filed (Month

5

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month 10:45A^M 2012 March <u>Leon Julian Pierre</u> 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Montgomery Collingswood Nursing Home Rockville 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign Social Security Number 1 💢 M 2 🗆 F Months Days Hours Min. (Month, Day, Yea Country)
W York, 1931 Feb. New 239-46-2779 Usual Residence of Decedent 10b. County 10d. Inside City Limits 10c, City, Town or Location 1 Yes 2 No Rockville Maryland Montgomery 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 299 Hurley Avenue 20850 United States 13. Was Decedent of Hispanic Origin? (Specify Yes or No-11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces?

1

X Yes 2 □ No
If Yes, Give
Year or Dates. 1950–53 Yes, specify Cuban, Mexican, Puerto Rican, etc. Black, White, etc. 1 Never Married 2 X Married 1 ☐ Yes 2 👿 No Specify: **Black** Specify 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Seconday (0-12) Music and Arts Artist 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Frances Moore Leon Julian Pierre Sr. 19a. Informant's Name/Relationship (Type, Print, 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 12020 Amber Ridge Circle #304, Germantown, MD 20876 Andre Julian Pierre, Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1
Burial 2
Cremation 3
Removal from State 3/12/2012 Brentwood, Maryland Ft. Lincoln Crematory 4 ☐ Donation 5 ☐ Other (Specify) MO1102 22. Name and Address of Facility Simple Tribute 21. Signature of Funeral Service License 1040 Rockville Pike, Rockville, Maryland 20852 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death)

Physician/ Medical Examiner

sician and burial

as

use

jo

detached

page 2 should

director,

this

within 24 hours after death.

To the Funeral Director: After thi completed filled in by the funeral

5

Completed

Be

မ

Certificate:

Medical

physician

that the death certificate be executed

P.O. Box 68760

Records,

Division of Vital

To the Hospital or Attending Physician: The law requires

Physician/

Examiner

Funeral

Director

or 28a-f show notified at

ms 23a or must be

ıral", or items ? Examiner mus

the Medical

"natural"

th and Mental Hygiene. 27 is marked other than traumatic event, the Me

item 2

permit. Page 1 a
Department of H
Important: If ite
any injury or ot

t. Page 1 and 2 should be fill tment of Health and Mental rtant: If item 27 is marked o

5

Director

Funeral

þ

Completed

Be

မ

within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

Medical

10a, State

one (cause on each line.
a .	Failure To Thrive Due to (or as a consequence of):
b.	Due to (or as a consequence of):
c.	Due to (or as a consequence of):
■ d.	

Sequentially list conditions, if any, leading to immediate Examiner Cause (Disease or iinjury that initiated events resulting in death) Last Physician/Medical IF FEMALE: 23b. Was decedent pre

in the past 12 mor

Yes

gnant ths?	23c. If yes, outcome of pregnanc 1 Live Birth 2 Fetal o 4 Pregnant at time of dea
0	
	0 Unicocura

3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ eath

23d. Date of delivery

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

2 🗌 N

Вe.	Did tobacc	o use cont	ribute to the caus	se of death?
	1 🗌 Yes	2 🗌 No	3 Probably	4 Unknow

26. Place of Death (Check only of

1 🗌 Yes	2 🗆 No	3 Probably	4 Unknow
4a. Was an	24b.	Were autopsy fin	dings available

Other 1 Inpatient 2 ER/Outp

TE TES ZE	140 3 Triobably 4 E Chikilow
24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?

25. Was case referred to medical examiner? 1 Yes 2 No
27. Manner of Death

28a. Date of injury (Month, Day, Year)

patient	3 □ □	DUA	4	Nursin
ne of ury	M	28c.	Injury at work? 1 🗌 Yes	2 🗆 No

	1 Yes 2 X	No 1 Tyes	2 🗆 No					
Check only one)								
ng Home	5 Residence	6 Other (Speci	ify)					

1 Natural 5 Pending Accident Investigation 6 Could not be Suicide ☐ Homicide determined

		M	1 □ `
ace of Injury - At ho	street,	factor	y, office

28b. Tir

	28d. Describe how injury occurred
□ No	
	28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier	1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, at
(Check	2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred a
only one)	3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place

28e. Pl

ertifying Physician: To the best of my knowledge, death occured at the time edical Examiner: On the basis of examination and/or investigation, in my opinion	e, date and place, and due to the cause(s) and manner as stated. ion, death occurred at the time, date and place, and due to the cause(s) and manner stated

b. Signatu	ire and₁t	itle of o	certifier
		c	1

ertifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29c. License number

29d. Date si	gned (Month,	Day, Yea	r)
72	C	-	

e and address of person who completed cause of death (Item 23a) (Type, Print) 10110

31. Date filed (Month, Day, Year)

6

101

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registra MEND#4a+3perMD, 3/15/12; EMW, MoCo Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death PERRY Month 5 Physician/ ORMAN 2012 Medical a. Facility Name (if not institution, give street and number)
Sunshine House II
612 Marti Lane 4b. City, Town, or Location of Death 4c. County of Death Examiner Annapolis Anne Arundel Birthplace (State or Foreign Country) Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8 Date of Rirth **Funeral** (Month, Day, Min 577-42-6375 84 Director 1 EM 2 D F July 24, 1927 Usual Residence of Decedent show 10a, State 10c. City, Town or Location 10d. Inside City Limits at регтіt. Page 1 and 2 should be filed within 72 hours after death with the Maryland Director or 28a-f sl 1 Yes 2 No MD Anne Arundel Annapolis 10e. Street and Number 10f. Zip Code ō 10g, Citizen of What Country? pe ms 23a c must be Funeral 612 Marti Lane 21401 USA "natural", or items edical Examiner mu 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? 11. Marital Status Race - American Indian. Completed by 1 Never Married 2 Married 1 X Yes 2 No Baltimore, Maryland 21215-0036 Specify: White 1 Yes 2 No Specify: Year or Dates. WWII 3 Widowed 4 Divorced and Mental Hygiene.
is marked other than "natur aumatic event, the Medical! 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Heating & Air Elementary/Secondary (0-12) College (1-4 or 5+) Conditioning Owner Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Health and Ment tem 27 is marked other traumatic e Norris R. Perry Lillian Virginia Overstreet 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health Important: If item 27 any injury or other trong once. Patrick J. Perry/Son 121 Chessie Court, Chester, MD 21619 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date March 2012 1 🔀 Burial 2 🗌 Cremation 3 🔲 Removal from State Fort Lincoln Cemetery Brentwood, MD 4 Donation 5 Other (Specify) 22 Name and Address of Facility Francis J. Collins Funeral Home Inc. 500 University Blvd. W., Silver Spring, MD 20901 21. Signature of Funeral Service Licensee 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Opset and Beath Immediate Cause (Final Physician/ ICNI disease or condition Medical resulting in death) **Examiner** ANCER 100 Sequentially list conditions, Examine if any, leading to infinediate cause. Enter Underlying Cause (Disease or injury that initiated events Hospital or Attending Physician: The law requires that the death certificate be executed and Due to (or as a consequence of): resulting in death) Last physician the buria Physician/Medical Division of Vital Records, P.O. Box 68760 attending ph JE FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ctopic pregnancy
5 Other (specify) in the past 12 months? Day Month Year Pregnant at time of death signed by the a Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 2 No 3 Probably 4 Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 1 Yes 2 No Yes after death.

Director: After this certific d in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Hospital Other: 1 ☐ Yes 2 ☐ No 2 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred injury work? 1 ☐ Yes 2 ☐ No 1 Natural 5 Pending Accident
Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, filled in by 4 Homicide determined City or Town, State) 24 hours a Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completely (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated within 2 only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 0 8 10+1 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) FENSEHWY, ANDAPOUS, M.D. 21401

DHMH 17 Rev 06-2011

State

Registrar

JEWEVIEVE 31. Date filed (Month, Day, Year)

MAR 0 6 201

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Medical Month O3 Day 2015 6:23 AM R. Pollitt Joyce 4a. Facility Name (if not institution, give street and number, **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Salisbury Coastal wi comica Hospice Lake at If Under 1 Year | If Under 24 Hrs. Social Security Number . Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Min. Days Hours Director 218-24-5986 1 M 2 M 83 Maryland 28a-f shov permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No Maryland Somerset <u>Princess</u> Anne 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 11229 Stewart Neck Road 21853 U.S. Was Decedent of Hispanic Origin? (Specify Yes or Nolf Yes, specify Cuban Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian. Armed Forces? Black, White, etc. Completed by 1 Never Married 2 Married 1 ☐ Yes If Yes, Give Maryland 21215-0036 1 Yes 2 No Specify 3 🗆 Widowed 4 🗆 Divorced Year or Dates White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) 1 2 College (1-4 or 5+) Teacher Education Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Jennings Richards Bernice Layfield 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Robert Pollitt Husband 11229 Stewart Neck Road, Princess Anne, Md. 21853 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place, 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Salisbury Crematory : 03/07/2012 Salisbury, MD. 22. Name and Address of Facility Hinman Funeral Home Signature of Funeral Service Licensee Þ 11673 Somerset Avenue, Princess Anne, Md. 21853 at 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest lock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ METASTATI disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23b. Was decedent pregnant IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 mont 1 Yes 2 No Month Pregnant at time of death Day Year n signed by the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an within 24 hours after death.

To the Funeral Director, After this certificate has I performe 1 Yes 2 No Be 25. Was case referred to redical 26. Place of Death (Check only one) examiner? Hospital Other: မ 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 L Other (Specify 27. Mann of Death 28a. Date of injury Certificate: 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred (Month, Day, Year) Watural 5 Pending 1 Yes 2 No Accident Investigation 6 Could not be 3 ☐ Suicide 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) TERN SHORE 910 State Registrar

50

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State of Maryla	•	artment of Healt		ygiene	10 00000
			Text Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death					112 10920
	Physicia	ın/				Month	Day	3. Time of Death
Albert Co. C.	Medic Examin		Susan T. Russe 4a. Facility Name (if not institution, give street and number)	11-Hicho	4b. City, Town, or Location	March	3 . 2	2012 6:05 A.M
	Examin	ei	7404 Cliffbourne Court		Derwood			itgomerv
	Funeral			s. last birthday)	If Under 1 Year If Und		Birth	9. Birthplace (State or Foreign
	Director		159-32-2103 1 □ M 2 🖾 F	7.2 Yrs.	Months Days Hour		Day, Year)	Country)
	ld 10w	٦	Coddi i Coddilet di Decedent	City, Town or Loc	cation	1 1 02/02	/1940	Pennsylvania 10d. Inside City Limits
	arylar a-f sl	Director						1 ☐ Yes 2 🔀 No
	he M. or 28 e noti		Maryland Montgomery 10e. Street and Number	Derwood	10f. Zip Code		10g. Citizen of V	What Country?
	with t	Funeral	7404 Cliffbourne Court		20855		Unite	d States
	leath items er m		11. Marital Status 12. Was Decedent Ever in Armed Forces?	U.S. 13. V	Vas Decedent of Hispanic Yes, specify Cuban, Mexi	Origin? (Specify Yes or N	0- 14. Rac	e - American Indian,
99	", or	þ	1 Never Married 2 X Married 1 Yes 2 X No		Yes 2 X No Spec		Specify:	ck, White, etc.
21215-0036	within 72 hours after death with the Maryland giene. er than "natural", or items 23a or 28a-f sho er than Medical Examiner must be notified at	Completed	3 Widowed 4 Divorced Year or Dates.	T 160 Doors	lent's Usual Occupation			White
5	72 h an "na Medik	шb	(Specify only highest grade completed)	(Give k	kind of work done during π O NOT use retired)	nost of working	160. Kind of Bi	usiness/Industry
212	withir giene er th		Elementary/Secondary (0-12) College (1-4 or 5+)	Reg	istered Nurs	e	Nurs	sing
pu	filed al Hy d oth	o Be	17. Father's Name (First, Middle, Last)		18. Me	other's Name (First, Midd	e, Maiden Surname	e)
Maryland	1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene, item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	2	Regis Fox			Elea	nor Wy	nn'nn
Mar	shou h and 7 is n traum		19a. Informant's Name/Relationship (Type, Print)	1	g Address (Street and Nur			
	pe 1 and 2 s t of Health If item 27 or other tra		George E. Hicho/Spouse 20a. Method of Disposition 20b	7404 7404 7404	Cliffbourne	Court, Derw		yland 20855 City or Town, State
nor	0 = =		1 🛣 Burial 2 ☐ Cremation 3 ☐ Removal from State	cemetery, crem	natory or other place)	1		
Baltimore,	permit. Page Department Important: I any injury o		4 Donation 5 Dotter (Specify)		eaven Cem. Name and Address of Fa			Spring,_MD
ñ	permit. Departr Imports any inje		Merlian / lele					rg, MD. 20877
			23a. Part 1. Enter the disease, or complications that caused the de shock, or heart failure. List only one cause on each line.	eath. Do not ente	er the mode of dying, such	as cardiac or respiratory	arrest,	Approximate Interval Between
	Physician/		Immediate Cause (Final disease or condition Cardiopulm	onary Ai	rest			Onset and Death
Topo to	Medical Examiner		resulting in death) Due to (or as a conse	equence of):				
15		in lie	Sequentially list conditions, b. Metastatic	Breast	Cancer			
	ed tab	Examiner	If any leading to him solete Cause. Enter Underlying Cause (Disease or injury	ніринения оку				
	xecut	Exa	that initiated events c. Due to (or as a conservation of the conservation)	equence of):				
09	ate be executed oblysician and the burial-transit	dical	d					
6876	ifficate by physical as the	Med	IF FEMALE:					
9 ×	eath certifica attending ph I for use as t	jan/	23b. Was decedent pregnant 23c. If yes, outcome of preging the past 12 months? 1 \sum Live Birth 2 \sum F	etal death 3				te of delivery
Вох	deat the at hed fo	Physician/Me	1 Yes 2 No 4 Pregnant at time of 9 Unknown	of death 5 ∟	Other (specify)		IVIO	onth Day Year
P.O.	hat the dea ed by the a detached t		Part II. Other significant conditions contributing to death but not	resulting in the u	nderlying cause given in P	art I. 23e. Did	I tobacco use contr	ribute to the cause of death?
S, F	ires that signed id be de	Completed by				1	Yes 2 X No	3 Probably 4 Unknown
ord	v requires been signal	Sete				24a. Wa		Were autopsy findings available
Sec.	The law ate has page 2	l lilo				pe	rformed?	prior to completion of cause of death? 1 □ Yes 2 □ No
alF	ician: The certificate rector, pag	Be C	25. Was case referred to medical examiner?		26. Place of D	Death (Check only one)	5 2 22 110	1 163 2 110
Χ	Physician: this certific al director,	일	1 Yes 2 X No 1 Inpatient 2		t 3 DOA Other: 4 D	Nursing Home 5 🛚 Re	sidence 6 - Othe	er (Specify)
ı of	tending P leath. or: After ti	ate:	27. Manner of Death 1 Natural Natural Natural 28a. Date of injury (Month, Day, Year)	28b. Time of injury	28c. Injury at work?		how injury occurre	ed
sior	ttend death stor: /	Certificate:	2 Accident Investigation 3 Suicide 6 Could not be 4 Unicide 6 determined 28e. Place of Injury - At	home form str	M 1 Yes 2		(Ctroat and Mumbe	er or Rural Route Number,
Division of Vital Records,	I or Atteno after death Director: /		4 Homicide determined building, etc. (Spec		set, factory, office		own, State)	er or nural noute Nurribel,
Ц	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Function Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-times.	Medical	29a. Certifier 1 X Certifying Physician: To the best of my known	owledge, death of	occurred at the time, date a	and place, and due to the	cause(s) and mann	ner as stated.
	the Ho	Med	(Check 2 Medical Examiner: Of the basis of examina only one) 3 Certifying Nurse Praditioner: To the best of					
	To To To To To To To To To To To To To T		29b. Signature and title of certifier		29c. License numbe	er	29d. Date signed	d (Month, Day, Year)
	20		- Jun -		D70759		March 5	, 2012
	,		30. Name and address of person who completed cause of death (It			Waahimataa	DC 200	0.7
	Sta	te	Dr. John F. Deeken, M.D., 3800 31. Date filed (Month, Day, Year) MAR 0 6 2012	nature	OLI KU., NW	, washington	υς 200	0 /
	Registr		31. Date filed (Month, Day, Year) 32 Registrar's Sig	A. 400	ula.			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 2. Date of Death 3. Time of Death 2^{Day} Physician/ March 2012 Patrick Allen Reed 12:30 PM Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Frederick 12004 North Street Libertvtown Social Security Number If Under 1 Year | If Under 24 Hrs. 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Yea 9. Birthplace (State or Foreign **Funeral** 216-88-4148 Maryland **Director** 6,1964 1**X** M 2 □ F 47 July 28a-f show 10a, State 10b. County 10c. City, Town or Location ral", or items 23a or 28a-f sho Examiner must be notified at Director MD Frederick Libertytown 1 Yes X No 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 12004 North Street 21762 United States 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 72 hours after 1 ☐ Yes 2X No Specify: "natural", Specify:White Completed 3 Widowed 4 Divorced Year or Dates other traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) marked other than Elementary/Secondary (0-12) College (1-4 or 5+) should be filed within and Mental Hygiene. Dairy Farmer Agriculture Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Francis Reed Mary Montgomery 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>.v</u> f Health a item 27 i Diana Reed (Wife) 12004 North St., Libertytown, MD 21762 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1 a
Department of H
Important: If ite
any injury or ot Date cemetery, crematory or other place) 1 Burial 2 X Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Smithsburg Crem. 3/6/2012 Smithsburg, MD 21. Signature of Funeral Service Licensee Reeney & Basford P.A. Funeral 106 E. Church St., Frederick, MO1612 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Disease Pulmonon Immediate Cause (Final Onset and Death CHIONIC Physician disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed and-train Due to (or as a consequence of) resulting in death) Last attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 the as IF FEMALE 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Day Year 1 Yes 2 9 Unknown 2 No 9 Unknown been signed by to should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Jas autopsy performed? Yes 2 No certificate 1 Yes 2 🗌 No 25. Was case referred to medical examiner?

1 Yes 2 No Be 26. Place of Death (Check only one) Hospital Other: မှ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 1 Natural 5 Pending in 24 hours after death.

In Funeral Director: After the fulling in by the fulling in by the fulling in the full in t 1 Yes 2 No Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier To the Hosp within 24 hor To the Fune completely fi Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated re and title of certifier 08062123 1 me and address of person, who completed cause of death (Item 23a) (Type, Print) FREDERICE, MA 196 TJORENE

Registrar DHMH 17 Rev 06-2011

State

50 LANUM

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 🤈 State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month D M VIRGINIA ANN MARC STEPHENS Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner FREDERICK MEMORIAL HOSPITAL FREDERICK FREDERICK 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 6. Sex 7. Age (In vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days July 28, 1 M 2 X F Months Hours Min Yea 1965 Was Wington, D.C. 212-02-9473 46 Yrs. Director Usual Residence of Decedent 28a-f show 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits with the Maryland Director notified Frederick Monrovia Maryland 1 Yes 2 No 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code ö ms 23a or must be r 21770 Funeral 4201 Lynn Burke Road items death v 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Examiner Armed Force Black, White, etc. ö þ 1 Never Married 2 Married Yes 2 No. filed within 72 hours after Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 🖾 No Specify: white Specify: "natural" 3 Widowed 4 Divorced Completed Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working Il Hygiene. life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Coffee Shop the Barrista other traumatic event, Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) and Mental Fis marked o မ Rosanne Huisman Irving Stephens Page 1 and 2 should be 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) it of Health a 1383 Fox Run Court, Frederick, Maryland Rosanne Stephens - mother Baltimore, 20a, Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State cemetery, crematory or other place) þ Department of Important: If any injury or 3-4-2012 Frederick, Maryland Stauffer Crematory 4 Donation 5 Other (Specify) 22. Name and Address of Facility Stauffer Funeral Home re of Funeral Service Ligensee Marou 21702 1621 Opossumtown Pike, Frederick, Maryland 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Physician/ neumonia disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Examir Cause (Disease or linjury that initiated events resulting in death) Last and burial-trar Due to (or as a consequence of): attending physician for use as the buria Physician/Medical The law requires that the death certificate be Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?

1 Yes 2 No 5 ☐ Other (specify) Month Day Year Pregnant at time of death the detached P.O. signed by d Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, 1 Tes 2 No 3 Probably 4 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy performed this certificate 2 🗌 No 1 Tes Yes 2 N To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director, After this certifica completed filled in by the funeral director. **Division of Vital** 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No ဂ္ 1 Tyes 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at work?
1 Yes 2 No 28d. Describe how injury occurred 5 Pending Natural Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 🗆 only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) March 2, 2012 M.D 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 21701 M.D. 400 Seventh Street, Frederick, Maryland Bennett, Donald R.

DHMH 17 Rev 7/2009

State

Registrar

31. Date filed (Month, Day, Year,

Registrar's Signature

resident.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

				epartment of Health and N	∕lental Hygi	ene	00023
Reg. No. Reg. No.						00020	
	Physicia	n/	1. Decedent's Name (First, Middle, Last)		Date of Death Month		3. Time of Death
	Medic		Mabel Virginia Smith 4a. Facility Name (if not institution, give street and number)	1.00.7	March	1 2012	5:30 A M
	Examin	er	13701 Graceham Road	4b. City, Town, or Location of Death Thurmont		4c. County of Death Frederick	
- menger	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birtho	(ay) If Under 1 Year If Under 24 Hrs.	8. Date of Birth	9. Birth	place (State or Foreign
	Director		219-20-3014 1 □ M 2 X F	Months Days Hours Min.	(Month, Day,	Year) Cour	ntry)
	ld now	_	Usual Residence of Decedent 86 10a. State 10b. County 10c. City, Town of the county	ar Location	Jan. 22		land
	arylar a-f sł fied ź	ecto	Maryland Frederick Thurmo				10d. Inside City Limits 1 Yes 2 No
	or 28	Dire	10e. Street and Number	10f. Zip Code	1	Og. Citizen of What Cou	
	e filed within 72 hours after death with the Maryland ital Hygiene. ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	Funeral Director	13701 Graceham Road	21788		U.S.A.	y.
	leath items ier mi		11. Marital Status 12. Was Decedent Ever in U.S.	13. Was Decedent of Hispanic Origin? (Spelf Yes, specify Cuban, Mexican, Puerto	ecify Yes or No-	14. Race - Americ	
36	after (", or	by	1 ☐ Never Married 2 ☐ Married Armed Forces? 1 ☐ Yes 2 Marvied If Yes, Give	1 Yes 2 No Specify:	nican, etc.)	Black, White,	
9	ours a	Completed	3 A Vildowed 4 Divorced Year or Dates.			Specify: Whi	
15	n 72 h an "na Medik	mp	(Specify only highest grade completed) (C	ecedent's Usual Occupation Give kind of work done during most of work fe. DO NOT use retired)	ing	16b. Kind of Business/In	dustry
212	within giene. er the		Liententary/Secondary (0-12) College (1-4 or 5+)	Homemaker		Home	
pu	be filed ental Hyy ked oth ic event		17. Father's Name (First, Middle, Last)	18. Mother's Nam	e (First, Middle, M	aiden Surname)	
ylai	ould be find Mental marked Imatic ev	ည	Lesley Stiltz	Helen Bo	one		
Jar	ge 1 and 2 should bo t of Health and Mer If item 27 is marke or other traumatic	7		Mailing Address (Street and Number or Rura			· ·
e, P	and 2 Health em 2; ther t		John Heleel Badgitel	827 Graceham Road,			
Baltimore, Maryland 21215-0036	Page 1 ment of I ant: If it		1 KBurial 2 Cremation 3 Removal from State cemetery,	crematory or other place)		20c. Location - City or To	
턆	artme artme ortan injury		4 Donation 5 Other (Specify) Resthav 21. Signature of Funeral Service Ucensee	en Mem.Garden Mar.			
Ba	permit. Page 1 and 2 Department of Health Important: If item 2 any injury or other 1 once.		The state of the activities of the state of	22. Name and Address of Facility Rob 615 East Main Stre			
			23a. Part 1. Enter the disease, or consplications that caused the death. Do not				Approximate
	Pnysician/	0 1	shock, or heart failure. List only one cause on each line. Immediate Cause (Final	heart failur	0		Interval Between Onset and Death
	Medical		disease or condition resulting in death) a. Due to (or as onsequence of):	- year facear	e		e mos.
	Examiner	_	Sequentially list conditions b. Cardiony	yopathy			6 mor.
	p ii q	nine	Sequentially list conditions, b. If any, leading to immodist cause. Enter Underlying				Vo-
	ecute and I-trans	xar	Cause (Disease or injury that initiated events resulting in death) Last C. Due to (or as a consequence of):	S(M			years
	ite be executed hysician and the burial-transit	dical Examine					
1200	icate g phys		d				
(887	eath certifica attending pl	an/N	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy	۵ 🗆 🕫		23d. Date of deliv	erv
Вох	ires that the death signed by the atterd be detached for	Physician/Me	1 Ves 2 No 4 Pregnant at time of death	3 Ectopic pregnancy 5 Other (specify)	·	Month	Day Year
o.	t the oby the stacker	Phy	9 Unknown 9 Unknown		1		
, P.O.	ss tha igned be de	þ	Part II. Other significant conditions contributing to death but not resulting in the			acco use contribute to the	
rds	require been si should	eted	Type II Diabetes mellite Peripheral arterial de		1 🗆 Ye	s 2 No 3 Pro	bably 4 🗆 Unknown
Records,	has b	Completed		sease_	24a. Was an autopsy	prior to co	psy findings available mpletion of cause of
Ä	nysician: The law nis certificate has t I director, page 2 s		Hypothyroidism 25. Was se referred to no ical		perform 1 Yes 2	death? No 1 Yes	2 N o
/ita	siciar certii lirecto	o Be	examiner? Hospital:	26. Place of Death (Check			
Division of Vital	g Physer this eral di	e: 10	27. Manner of Death 28a. Date of injury 28b. Tim	ne of 28c. Injury at	me 5 Pesider 28d. Describe hov	nce 6 Other (Specify)
nc	l or Attending after death. Director: After din by the fune	Certificate:	1 ☑ Natural 5 ☐ Pending (Month, Day, Year) inju 2 ☐ AccidentInvestigation	ıry work? M 1 ☐ Yes 2 ☐ No		injury occurred	
/isi	r Atte	ertif	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e. Place of Injury - At home, farm building, etc. (Specify)	, street, factory, office		eet and Number or Rural	Route Number,
ă	ital o ral Di lled ir				City or Town,	•	
	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Medical	29a. Certifier (Check 2 Medical Examiner: On the basis of examination and/or in	nvestigation, in my opinion, death occurred at	the time, date and	place, and due to the car	use(s) and manner stated
	o the o the omple	ž	only one) 3 Certifying Nurse Practitioner: To the best of my knowle 29b. Signature and (Tipe) spriller	edge, death occurred at the time, date and pla 29c. License number	ace, and due to the	cause(s) and manner as	stated.
	r > F 0		1 Sosbertan	D22819		d. Date signed (Month, a)	
			30. Name and address of person who completed cause of death (Item 23a) (Tyr			March 1	1000
	9		BRAD J. COOPER, M.D. 5.	2 WATER ST, THU	CRMONT	, MD. 21	788
	Stat	┖	31. Date filed (Month, Day, Year) 32. Registrar's Signature	De Print) 2 WATER ST, THE			
	Registra	r	MAR 0 5 2012 Deneur B.	E ares			

Physician /Medical Examiner The law requires that the death certificate be executed

Physician

Examiner

Funeral

Director

ns 23a or 28a-f show must be notified at

permit. Pages 1 and 2 should be filed within 72 hours after death with 1 Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or Items 23a or 3 any Injury or other traumatic event, the Medical Examiner must be n

Saltimore, Maryland 21215-0036

Director

Funeral

2

Completed

Be

ဂ္

the Maryland

/Medical

Examiner burial-tran physician attending pl for use as t been signed by the should be detached To the Hospital or Attending Physiclan: within 24 hours after death.

To the Funeral Director: After this certifica nours after death.

Ineral Director: After this y filled in by the funeral di

Division or Vital Records, P.O. Box 68760,

Physician/Medical ģ Completed Be P Medical Certification:

1 ☐ Yes 2 No

27. Manner of Death 1∉X Natural 2 ☐ Accident 3 Suicide 4 Homicide 29a, Certifier (Check only one)

determined Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

6 ☐ Could not be

Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28b. Time of 5 ☐ Pending investigation

0

28c. Injury at Work?

1 ☐ Yes 2 ☐ No 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

29c. License number

D48098

29d. Date signed (Month, Day, Year) 3/6/2012

28f. Location (Street and Number or Rural Route Number, City or Town, State)

28d. Describe how injury occurred

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

10. Name and address of person who completed cause of death (Item 23a) (Type, Print)

11. Land Hall Highway, Criffield MD21817

31. Date filed (Month, Day, Year) MAR 06 2012

29b. Signature and title of certifier

32. Registrar's Signature

State Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Smith 2012 illie 0527 AM Medical 4a. Facility Name (if not institution, give street and number, 4b. City, Town, or Location of Death County of Death **Examiner** Wicomico regional Medical 8. Date of Birth (Month, Day, Year) If Under Birthplace (State or Foreign Country) f Under 24 Hrs. **Funeral Director** 1 **X** M 2 □ F Alabama 28a-f shov 10b. County 10c. City, Town or Location must be notified at 10d, Inside City Limits Funeral Director 1 XYes 2 No Cristiel Mariland ō 10f. Zip Code 10g. Citizen of What Country? 23a 2181 Pine U.S.A items Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Medical Examiner Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates. Black, White, etc. 1 Never Married 2 Married 9 þ Maryland 21215-0036 1 ☐ Yes 2 No Specify 3 ☐ Widowed 4 ☐ Divorced "natural", Specify: Black Completed Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) Give kind of work done during most of working and Mental Hygiene. is marked other than life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Chadwick manutadus 12+4 Packer Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, 2 James 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is any injury or other trau Williams-Laughter 54. Sherrice Baltimore, 20a. Method of Disposition

1
Burial 2 Cremation 3
Removal from State 20b. Place of Disposition (Name of 3/12 4 Donation 5 Other (Specify) remator, of Signature of Funeral Service Licensee YE. Ward Fitt. 21853 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Ph. i i.n. disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) attending physician and for use as the burial-transit Cause (Disease or injuly that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No 5 Other (specify) Month Dav Year Pregnant at time of death signed by the at Id be detached for Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Division of Vital Records, 1 Yes 2 No 3 Probably 4 Onknown page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No 24a Was an has performe within 24 hours after death.

To the Funeral Director: After this certificate 25. Was case referred to edical completely filled in by the funeral director, Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) ည 1 🗌 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work?
1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred Natural injury 5 Pending Accident Investigation Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and

State Registrar

DHMH 17 Rev 06-2011

ause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Physician/ Month Year 548 PM Susan Rebecca Smith march 20/2 Medical 4a, Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** Meritus Medical Center Hagerstown Washington 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign **Funeral** (Month, Day, Year, Director 219-68-7281 1 🗆 M 2 🗶 F Yrs May 15, 53 1958 Virginia Usual Residence of Decedent items 23a or 28a-f show her must be notified at 10c. City, Town or Location 10a State 10h County 10d Inside City Limits Director 1 Yes 2 No Maryland Washington Funkstown 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Funeral 21734 USA 200 East Chestnut Street Apt.11 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, an "natural", or iter Medical Examiner Armed Forces? Black, White, etc. 2 1 Never Married 2 X Married If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: Specify: 3 Widowed 4 Divorced Completed White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working nd Mental Hygiene. marked other than life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) the 12 Store Manager Convenience Store Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Should be file and Mental H ၉ Donald Robert Gindlesberger, Sr. Charlotte Oneida Oertly 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 200 E. Chestnut Street Apt.11 Funkstown, MD 21734 item 27 Michael A. Smith (Husband) other 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State ₽ cemetery, crematory or other place) Important: If 1 Burial 2 X Cremation 3 Removal from State injury or Hagerstown Crematory Mar. 10, 2012 Hagerstown, Maryland Donation 5 Other (Specify) 22. Name and Address of Facility Osborne Funeral Home P.A. Signa 425 S. Conococheague St. Williamsport, MD 21795 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each lipe. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Medical Examiner Sequentially list conditions, Examiner Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Cause (Disease or injury and burial-tran that initiated events Due to (g resulting in death) Last physician Physician/Medical the as attending IF FEMALE nse 23c. If yes, outcome of pregnancy 1 Live Birth 2 Li Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) 1 Live Birth
4 Pregnant
9 Unknown in the past 12 months? should be detached for Month Day Year Pregnant at time of death the 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of page 2 certificate has autopsy death? 2 No Yes funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospita Other: 1 Yes 2 No မှ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at 28b. Time of Certificate: 28d. Describe how injury occurred Director: After Natural 5 Pending 1 Yes 2 No the f Accident Investigation Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 28f. Location (Street and Number or Rural Route Number, 4 Homicide City or Town, State)

To the Hospital or Attending Physician: The law requires within 24 hours after death.

To the Funeral Director: After this certificate has been significate to the Funeral Director. After this certificate has been significate to the Funeral Director.

Saltimore, Maryland 21215-0036

Box 68760

P.O.

State Registrar

Medical

29a. Certifier (Check

29b. Signature and

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

339

MD

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

East antietan

21740

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ March 3:05 a M EVELYN VIRGINIA SWART Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner enter If Under 1 Year If Under 24 Hrs. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Hours Min 578-28-1171 **Director** 1 M 2 F 86 Yrs. 2-21-1926 W.VA. Usual Residence of Decedent 28a-f shov 10a. State 10c. City, Town or Location 10d. Inside City Limits notified at Funeral Director MD. PRINCE GEORGES 1 🗌 Yes 💥 No BRANDYWINE Jart, Evelyn M278/4. Baltimore, Maryland 21215-0036 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? must be items 23a 20505 CEDARVILLE ROAD 20613 U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Examiner Black, White, etc ò þ 1 Never Married 2 Married 1 ☐ Yes 2 XNo If Yes, Give Year or Dates. 1 ☐ Yes 2 🔀 No Specify: 3

Widowed 4 □ Divorced Specify: WHITE Completed the Medical Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working Il Hygiene. life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) HOMEMAKER OWN HOME Be other traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Department of Health and Mental I Important: If item 27 is marked o any injury or other traumatic eve မ SAMUEL AUSTIN BURDETTE ADA LURA WYCKLE 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) CAROL FLEWELLING-DAUGHTER 18807 AQUASCO RD. BRANDYWINE, MD. 20613 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 Durial 2 XCremation 3 Removal from State METROPOLITAN CREMATORY 3-14-12 ALEX., VA 4 ☐ Donation 5 ☐ Other (Specify) permit. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 21. Signature of Funeral Service Licenses 22 Name and Address of Facility Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ bleeding abdominal disease or condition -dan Medical resulting in death) Due to (or as a consequence of **Examiner** OPD Sequentially list conditions, if any hadding to important cause. Enter Underlying Cause (Disease or injury that initiated events Examine Due to lor as a consequence of To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attendion abused on the control of physician and the burial-trans Due to (or as a consequence of) resulting in death) Last igned by the attending physician be detached for use as the buria Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death

4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ 1 Live Birth
4 Pregnant
9 Unknown in the past 12 months?
1 ☐ Yes 2 ☐ No Month Year Day 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed' death? 2 No Yes eral Director: After this certificatilled in by the funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner?

1 Yes 2 No Hospital Other: 은 1 Anpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 14 Natural 5 Pending injury work 1 Yes 2 No 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 29b. Signature and title of certifier 069566

State Registrar MO

32. Registrar's Sigrature

Garrett Avenue,

La Plate, MD 20646

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year)
WAR 2 1 2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			1 - State State Registrar	of Maryland / Depa <i>Cer</i>	artment of H tificate of D		, ,	ene g. No. 2 N	2 08928	
	Physicia	in/	1. Decedent's Name (First, Middle, Last) VERONICA NMI TOTH 2. Date of Death Month March 04 Day 2012						3. Time of Death 12.30 M	
No. of Street, or other Persons	Medio Examir		4a. Facility Name (if not institution, give street and number of the st	mber)	4b. City, Town, or i		march 0	4c. County of Death		
Sangar.	<u>-</u>		Citizen's Nursing Home 5. Social Security Number 6. Sex	Freder	If Under 24 Hrs.	8. Date of Birth	Freder			
	Funeral 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 7. Age (In yrs. last birthday) 89 Yrs.					Hours Min.	(Month, Day, Y	'ear)	Birthplace (State or Foreign Country)	
	nd how at	ž	Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or Lo	cation		Nov. 14,	1922 H	urgary 10d. Inside City Limits	
	Marylar 28a-f s otified	recto	MD Frederick	Frederi					1 X Yes 2 □ No	
	th the	Funeral Director	10e. Street and Number 1900 Rosemont Avenue		10f. Zip Code 21702)	10	g. Citizen of Wha	t Country?	
	eath w	Fune	11 Marital Status 12. Was Dec	edent Ever in U.S. 13. V	Was Decedent of His f Yes, specify Cuban		ecify Yes or No-	14. Race - /	American Indian,	
21215-0036	ge 1 and 2 should be filed within 72 hours after death with the Maryland to f Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at	by	1 Never Married 2 Married 1 Yes 3 M Widowed 4 Divorced Year or D	2 🗂 No ive 1	f Yes, specify Cuban I ☐ Yes 2 🔀 No		Rican, etc.)	Black, V Specify:	White, etc. White	
15-	72 hoin "nat	Completed	15. Decedent's Education (Specify only highest grade completed	(Give I	lent's Usual Occupa kind of work done du O NOT use retired)	tion uring most of work	ing 1	6b. Kind of Busin	ess/Industry	
	l within ygiene. her tha t, the l		1.2	1-4 Or 5+)	stodian			High Sch	1001	
land	d be filed dental H rrked ott tic even	To Be	17. Father's Name <i>(First, Middl</i> e, <i>Last)</i> Elek Telepcsack			18. Mother's Nam Maria	e (First, Middle, Ma Fecsku	iden Surname)		
, Maryland	d 2 should alth and M n 27 is ma er trauma		19a. Informant's Name/Relationship (Type, Print) Victoria V. Gerard / Da	ughter 402 I	ng Address (Street ar Rockwe11	nd Number or Rura [errace,	Route Number, C Frederic	ity or Town, State k, Maryl	and 21701	
Baltimore,	permit. Page 1 and 2 s Department of Health Important: If item 27 any injury or other tr once.		20a. Method of Disposition 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from	ii Otate	natory or other place)		0c. Location - Cit		
altim	t. Pa tmer tant jury		4 Donation 5 Other (Specify) 21. Signature of Funeral Service icenty		Cath. Cer				Maryland	
B	permir Depar Impor any in		Prest E Juli	Ro	Name and Address 201 North obert E. I	Market S Dailey &	Street, F Son_F.H.	rederick , P.A.	, MD 21701	
Physician/ Medical Examiner 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mod shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any bodium that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of):				ENTIN	9			Approximate Interval Between Onset and Death		
09289	Hospital or Attending Physician: The law requires that the death certificate be executed hours after death. Funeral Director: After this certificate has been signed by the attending physician and tely filled in by the funeral director, page 2 should be detached for use as the burial-transit	edical	d	(or as a consequence of):						
. Box (t the death ce by the attenc stached for us	Physician/M	in the past 12 months?	e Birth 2 ☐ Fetal death 3 ☐ gnant at time of death 5 ☐	Ectopic pregnancy Other (specify)			23d. Date of Month	f delivery Day Year	
s, P.O.	iires that the signed by ald be deta	by	Part II. Other significant conditions contributing to	death but not resulting in the u	nderlying cause give	en in Part I.			e to the cause of death?	
Division of Vital Records,	The law require ate has been si page 2 should	Completed					24a. Was an autopsy performe	prior deat	24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 □ No	
tal	ysician: The is certificate director, pag	Be	25. Was case referred to medical examiner?	- Files	26. Plac	ce of Death (Check		2110	TOO ZELINO	
n of V	iding Phys th. After this funeral dis	cate: To	1	Inpatient 2 ER/Outpatien e of injury oth, Day, Year) 28b. Time of injury	28c. Injury work?	4 Nursing Ho	me 5 Resident 28d. Describe how		pecify)	
28a. Date of injury 28b. Time of injury at work? 28c. Injury at							28f. Location (Stree City or Town, S		Rural Route Number,	
_	To the Hospital or Attendii within 24 hours after death. To the Funeral Director: Af	Medical	only one) 3 Certifying Nurse Practitione	sis of examination and/or invest	gation, in my opinion	i, death occurred at	the time, date and	place, and due to t	the cause(s) and manner stated.	
	To wit		29b. Signature and title of certifier	MA	29c. License (Print)	number 0 6 / W/	290	d. Date signed (Me	onth, Day, Year) 05, 2012	
	\		30. Name and address of person who completed cau	se of death (Item 23a) (Type, P	Print)	11000			104 140	
	Sta	e.	GOFFAR SYE 31. Date filed (Month, Day, Year) 32. F	egistrar's Signature	1000	70056	, FR	EDER	ICK, MD	
	Registra		MAR 0 5 2012	ensur B. A	arked					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

George Turner,		State of Maryland / Department of Heal 1- For State Certificate of Deal			eg. No. 201	2 0892
Physic Medical Exam		Decedent's Name (First, Middle, Last)		2. Date of Deat Month	h Day Year	3. Time of Deeth
		<u>George Franklin Turner, Jr.</u>	Town, or Location of Deat	March 14,	2012 4c. County of Dea	1014 hrs
		474 440 1 0 4	rstown		Washington	ui
Funeral					h(MM/DD/YYYY) 9. B	
Director		213-98-5653 1 XM 2 F 43 Yrs.	s Days Hours Mi		22 1968 Fore	^{ountry)} Mary1and
'n	ĺ	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location				10d. Inside City Limits
E	Ļ	N 1 1 1				1 X Yes 2 No
Maryland 28a-f show d at once,	ecto	Maryland Washington Hagerstown 10e. Street and Number 10f. Zip	Code	10	g. Citizen of What Cou	
3 or otified	₫	471 Mitchell Avenue 2	1740		USA	
D 21215-0036 should be filed within 72 hours after death with the Maryland and Mental Hygiene. 7 is marked other than "natural", or items 23a or 28a-f abouatic event, the Medical Examiner must be notified at once.	Funeral Director	11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decede	nt of Hispanic Origin? (S y Cuban, Mexican, Puert	Specify Yes or No-	14. Race - Ame White, etc.	rican Indian, Black,
ter dea ", or it	E	1 Yes 2 No	No specify:			71
ours af ntural camin	d by	15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual	Occupation (Give kind of	work done	Specify: V	/hite /Industry
16 172 ho	Completed	College (1-4 of 5+)	king life. DO NOT use re	tired)		
OO3 withingsiene.	omi	9 0 Dispatel			Taxi Co	ompany
21215-0036 uld be filed within 7 Mental Hygiene. marked other than e event, the Medica	Be C	George Franklin Turner, Sr.		e (First, Middle, M	·	
21, nould b d Men is mar	Tol	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address	(Street and Number or	ine Selle Rural Route Numb	ers City or Town, State	e, Zip Code)
≥ da san san san san san san san san san sa		George F. Turner, Sr Father 14407 Man	rsh Pike, Ha			
F E E		20a. Method of Disposition 1 X Burial 2 Cremation 3 Removal from State 20b. Place of Disposition (Nan crematory or other place)		Date	20c. Location - City or	Town, State
Baltimore, permit. Pages I ar Department of Hes Important: If ite injury or other tr		4 Donation 5 Other Specify: Rose Hill Cem	etery 3/2	20/2012	Hagerstown	n, Maryland
Depa Inpo		Transfer (neral Home	
Physician		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of failure. List only one cause on each line. Mixed Drug (Oxycodone,	Wilson Blv f dying, such as cardiac c	or respiratory arres	et shock or heart	Approximate Interval
/Medical £xaminer		Immediate Cause (Final disease a. Nordiazapam) Intoxica		poxide a	щ	Between Onset and Death
A		or condition resulting in death) Due to (or as a consequence of):				
	ner	Sequentially list conditions, if any, leading to immediate Due to (or as e consequence of): cause. Enter Underlying Cause				-
	Examiner	(C)isease or injury that initiated events resulting in death) Last Due to (or as a consequence of):				
760, cate be executed physician and ne burial - transit	E E	d				
60, ate be ex hysician e burial	Medical	☑ UNPENDED ☐ AMENDED 23a,27,28a-f per m	e g925 3-28	-12 vt		
876 tificate ng phy as the	cian/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death	3 Ectopic pregna	encv	23d. Date of delivery) Day Year
Box 6876: death certifical the attending pheat for use as the	SICE	4 Pregnant at time of death 5 Other (Spec				104
the de	Physic	Part II. Other significant conditions contributing to death but not resulting in the underlying	Cause diven in Part I	23e Did tob	acco use contribute to	the cause of death?
P.O. res that the signed by be detach	2	g in the distance of the second of the secon	Adde given in a bit i.	I	2 No 3 Prob	
rds, requir been s	ompleted			24a. Was an		topsy findings available
Reco The law cate has	E C			autopsy	ned? death?	ompletion of cause of
al R	S S		6.Place of Death (Check	1 ✓ Yes 2 only one)	No 1 ✓ Ye	s 2 No
of Vital Records, by Physician: The law require. The thus requirent this certificate has been some a director, page 2, should	2	examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 DO	OA Other Nursin	ng Home 5 Re	esidence 6 🗸 Other	: Scene
ding Ph		(Month, Day, Year)	3c. Injury at Work?	28d. Describe ho	w injury occurred	
Division tal or Attendia s after death. al Director: A	Cati	2 X Accident Investigation fd 3-14-12 fd 10:00am			took medic	
Div	Certification	Suicide Suicide Gould not be determined (Specify) residence	Ance building, etc.	or Town, Stat	eet and Number or Runtel te) 471 Mitcl	
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transi		29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the	ime, date and place, and	Hagersto	s) and manner as state	ed.
To the within To the compl	Medical	one) 2 Medical Examiner: On the basis of examination and/or investigation, in my and manner stated.	opinion, death occurred a	it the time, date en	nd place, and due to the	cause(s)
	2		O.C.M.E.		29d. Date signed (Mon	th, Day, Year)
	-	30 Name and address of person who completed cause of death (Item 23e)			March 15, 2012	
			more Street, Baltim	ore, MD 2122	23	
		31. Date filed (Month, Day, Year) NAR 2 1 2012		- -		
Regist	retr	MAR 2 1 2012 James B. Janes			OCME .	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ George Eugene Tracey, Sr. 8:34 A M March 2012 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Washington Meritus Medical Center Hagerstown Social Security Number If Under Year If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday **Funeral** 8. Date of Birth (Month, Day, Year) 215-42-3265 **Director** 66 Jan. 22, 1946 Maryland Usual Residence of Decedent 28a-f show ms 23a or 28a-f sho must be notified at 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No Maryland Frederick Smithsburg 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 14003 Loy Wolfe Road 21783 U.S.A. Page 1 and 2 should be filed within 72 hours after death vent of Health and Mental Hygiene. ant. If item 27 is marked other than "natural", or items 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Examiner Completed by 1 Never Married 2 Married 1 ☐ Yes 2 🔀 No If Yes, Give Baltimore, Maryland 21215-0036 1 Yes 2 X No Specify: 3 - Widowed 4 X Divorced White Year or Dates. other traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Machine Company 10 Machinist Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Wilmer M. Tracey Ruth V. Kline Department of Health and I Important: If item 27 is may any injury or other traums 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) (Son) 13256 Herman Myers Rd. Hagerstown, Maryland 21742 George E. Tracey II 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place)
Mt. Bethel United
Methodist Ch. Cemetery 1 X Burial 2 Cremation 3 Removal from State March 4 ☐ Donation 5 ☐ Other (Specify) Foxville, Maryland 16, 2012 Signature of Funeral Service Licensee 22. Name and Address of Facility J.L. Davis Funeral Home 12525 Bradbury Ave. Smithsburg, Maryland 21783 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Ph_sician/ ENCEPHACOPATHY disease or condition Medical resulting in death) Examiner Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Exami CPIRATORY and burial-trar Due to (or as a consequence of) resulting in death) Last attending physician Physician/Medical requires that the death certificate be P.O. Box 68760 the as IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year Pregnant at time of death the 9 Unknown Unknown signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Completed by PNEUMONIA Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown peen 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? within 24 hours after death.

To the Funeral Director. After this certificate has I completely filled in by the funeral director, page 2. To the Hospital or Attending Physician: The law performed? 2 🗌 No 1 🗌 Yes 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital 1 Yes ပ Inpatient 2 ER/Outpatient 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death Date of injur 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred Natural (Month, Day, Year) 5 Pending 1 Yes 2 No Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Medical Descritifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Description of the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier 3 🗆 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of eart/fie 29d. Date signed (Month, Day, Year) 0

00

State Registrar 31. Date filed (Month, Day, Year NAR 2 1 2

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene = State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Ronald Lee Williams March 0658 1 Medical 2012 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death AL136414 Comia If Under 1 Year If Under 24 Hrs. **Funeral** Birthplace (State or Foreign Country) 8 Date of Birth Months Days Min (Month, Day, Year) **Director** 230-94-7253 1 □XM 2 □ F 52 Yrs Sept. 21,1959 VA Usual Residence of Decede or 28a-f show 10c. City, Town or Location the Medical Examiner must be notified at Director 10d. Inside City Limits VA Accomack Chincoteague 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral or items 23a 8181 Seashell Drive 23336 USA within 72 hours after death 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian Black, White, etc. \$ 1 Never Married 2 XMarried Yes 2X No Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: "natural", White Completed 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than 'any injury or other traumatic event, the Me Elementary/Secondary (0-12) College (1-4 or 5+) Construction Carpenter Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Ronald Eugene Williams Shirley Hart 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mary Lou Williams - Wife Seashell Drive, Chincoteague, VA 23336 8181 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 🔀 Burial 2 🗆 Cremation 3 🗀 Removal from State cemetery, crematory or other place. 4 Donation 5 Other (Specify) March 8,2012 Daisey Cemetery Chincoteague, VA 21. Signatur of Fineral Service Licenses 22. Name and Address of Facility Thornton Funeral Home, Inc. 24183 Chadbourne St., Parksley, VA 23421 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ Nyocardea disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Cause (Disease or injury that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Pregnant at time of death 5 Other (specify) Day Year ate has been signed by the a page 2 should be detached to 2 🗌 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform performed? 1 ☐ Yes 2 ☐ No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospita 2 No Certificate: To 1 🗌 Yes 1 🗌 Inpatient 2 🗹 ER/Outpatient 4 Nursing Home 5 Residence 6 Other (Specify) Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) 5 Pending Natural ☐ Accident 1 Tes 2 No Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certif 29d. Date signed (Month. Dav. Year) 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 4049 Main Street, Chincoteague, Dr. Daniel Carl Cochran

DHMH 17 Rev 06-2011

State Registrar 31. Date filed (Month, Day, Year)

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Day 23, 2012 11:40 A M Richard Dulaney Wheatley Feb. /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death 31471 Orchard Terrace Road Somerset Westover If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days 1₫M 2□F Director 219-36-5243 Usual Residence of Decedent 71 May 28, 1940 Maryland Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. 10a. State 10b. County 10c. City, Town or Location "natural", or items 23a or 28a-f show edical Examiner must be notified at 10d. Inside City Limits Directo 1 Yes 2 No Maryland Somerset Westover 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 31471 Orchard Terrace Road 21871 by Funeral U.S. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1959-63 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: 3 ☐ Widowed 4 ☐ Divorced White Completed the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 12 <u>Building Contractor</u> Construction 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be n and Mental ဥ John Dulaney Wheatley Emily Webster 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) f Health a Teresa Wheatley 31471 Orchard Terrace Road, Westover, Md. 21871 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages Department of Important: If It any Injury or o 1 Burial 2 □ Cremation 3 □ Removal from State 02/29/12 4 ☐ Donation 5 ☐ Other (Specify) Beechwood Cemetery Princess Anne, Md. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Hinman Funeral Rome PA / MOO295 11673 Somerset Avenue, Princess Anne, Md. 21853 Part Enter the disease, or complications that used the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, thou or heart failure. List only one cause on ach line. te Cause (Final ulb-lame lioblastoma **Physician** ing in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Examiner The law requires that the death certificate be executed that initiated events resulting in death) Last and Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760. attending physician Physician/Medical 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? **p** 1 ☐ Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No autopsy performe Hospital or Attending Physician: 25. Was case referred to medica examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Desidence 6 Other (Specify) Hospital: 1 ☐ Yes 2 ☐ No 2 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Certification: 28c. Injury at Work? 28d. Describe how injury occurred 1 Accident 5 Pending investigation Injury the Funeral Director: A 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 Descriping Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only and manner stated. the 29b. Signature and tle of certifier 29c. License number 29d. Date signed (Month, Day, Year) D0066198 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Justinian Ngaiza, mo 95x+6 100 E. Carroll St., Salisbury, mo 21801 31. Date filed (Month, Day, Year) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 0:25PM Medical rnice 2012 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Charle ri UC ato gnolic If Under 1 Year 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Hours (Month, Day, Year) 9-38-4816 Director 1 M 2 KF irginia 28a-f show at 10a. State 10b. County 10c. City, Town or Location Director 10d. Inside City Limits item 27 is marked other than "natural", or items 23a or 28a-f slother traumatic event, the Medical Examiner must be notified. Md Head 1 🗌 Yes 2 🇷 No 10e. Street and Number 10g. Citizen of What Country? Funeral 20640 filed within 72 hours after death 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 2 No Black, White, etc. 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No If Yes, Give Year or Dates 3 ▼ Widowed 4 □ Divorced Specify Black Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname ber Johnson Sie Rural Route Number, City or Town, State, Zip Code) 20640 19a._Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Wast Son mon 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State Important: If it any injury or o 1

■ Burial 2

□ Cremation 3

□ Removal from State Oak Grove 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Incensee P.O. BOX 11 Brooks uneral Va. 22535 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death Physician! disease or condition mound Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if an, leadin, to immediate cause. Enter Underlying Cause (Disease or injury that Initiated events resulting in death) Last Examine Due to (or as a consequence of): Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be Box 68760 attending plant of the season use as IF FEMALE 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Dav Year Yes 2 No Pregnant at time of death ed by the at 9 Unknown 9 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. signed k 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🙀 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an within 24 hours after death.

To the Funeral Director: After this certificate has k completely filled in by the funeral director, page 2 s autopsy 1 Yes 2 No 1 ☐ Yes 2 🗶 No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital Other: 2 No မ 1 Tyes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify, 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Accident work? 1 Yes 2 No 5 Pending Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 06-2011

State Registrar 31. Date filed (Month, Day, Year)

ODE am Problect

ad Washington

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registra Certificate of Death Reg. No. I. Decedent's Name (First, Middle, Last) 2. Date of Death J'ear Physician/ MEL ounci 11.15AM Medical 4a. Facility Name (if not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Montgomery Burtonsville Sanctuary at Holy Cross 8. Date of Birth 9, Birthplace (State or Foreign Country) **England** . Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 5. Social Security Number **Funeral** Months Days Hours Min 1 M 2 XF 09/08/1927 217-72-8515 Yrs 84 **Director** Usual Residence of Decedent 28a-f shov 10c. City, Town or Location 10d. Inside City Limits filed within 72 hours after death with the Maryland er than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at Director 1 Yes 2 No Silver Spring Maryland Montgomery 10f. Zip Code 10e. Street and Number 10g, Citizen of What Country Funeral Canada 20905 605 Avon Square Court Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Armed Forces?
1 ☐ Yes 2 🕱 No Black, White, e 1 Never Married 2 Married þ White Baltimore, Maryland 21215-0036 1 Yes 2 No Specify. If Yes Give Specify 3 Widowed 4 X Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed, American Society of al Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) International Law 12 Administrative Assistant Be event, 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) should be file h and Mental F marked Eileen Mary Stacey Leonard Pearce other traumatic and is m 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 st Department of Health ar Important: If item 27 is any injury or other trau 605 Avon Square Ct., Silver Spring, Maryland 20905 Christina Levin - Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 🗆 Burial 2 🗶 Cremation 3 🗀 Removal from State Lincoln Crematory 03/09/2012 | Brentwood, Maryland 4 Donation 5 Other (Specify) 22. Name and Address of Facility Hines-Rinaldi Funeral Home, Inc. Signature of Funeral Service Licensee 11800 New Hampshire Ave., Silver Spring, MD 20904 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line Onset and Death Immediate Cause (Final Physicism disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or linjury Examine Due to lor as a consequence of signed by the attending physician and be detached for use as the burial transit that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 Yes 2 No Month Year Pregnant at time of death 1 Yes 2 le g Unknown g Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 Yes 2 No 3 Probably 4 Unknown Completed page 2 Certificate: To Be

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director; After this certificate has been signed by the attending physician and Division of Vital Records, P.O. Box 68760 pleted filled in by the funeral

					V	
				24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No	
25. Was case referred to medical		2	26. Place of Death (Chec	k only one)		
examiner?	Hospital:	R/Outpatient 3 DOA	Other: Nursing H	ome 5 Residence 6	Other (Specify)	
27. Man of Death 1 Natural 5 □ Pending 2 □ Accident Investigation	(Month, Day, Year)	injury	Injury at work? 1 Yes 2 No	28d. Describe how injury occurred		
3 ☐ Suicide 6 ☐ Could not 4 ☐ Homicide determined		e, farm, street, factory, of	28f. Location (Street and Number or Rural Route Number, City or Town, State)			

Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signat and title of certifie 29c. License number

Medical Examiner: On the basis of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year)

Name and address of person who completed cause of death (Item 23a) (Type, Print)

1525 MILL WINGS

31. Date filed (Month, Day, Year) 6

State

Registrar

Medical

29a, Certifie

(Check only on

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 🤈 🎧 For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 12:50 am Ruvan Zusin 2012 March Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4521 East-West Highway Bethesda Montgomery Social Security Number If Under 1 Year 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) **Funeral** 218-25-3246 **Director** 1 🗗 M 2 🗆 F 82 March 07,1929 Belarus Usual Residence of Decedent show the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits Director notified 28a-f Maryland Bethesda 1 🗌 Yes 2 🎗 No Montgomery 10e. Street and Number ō 10f. Zip Code 10g. Citizen of What Country? must be Funeral Page 1 and 2 should be filed within 72 hours after death with 1 ment of Health and Mental Hygiene. Page 1 should be 1 it file 12 is marked other than "natural", or items 23a ury or other traumatic event, the Medical Examiner must b 4521 East-West Highway 20814 U.S.A. 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces? Black, White, etc. by 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: If Yes, Give Year or Dates 3 Widowed 4 Divorced Specify: White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Shoe Maker Shoe Making Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, ပ Shemon Zusin Bela (Unknown) 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9723 Pleasant Gate Lane, Potomac, Maryland 20854 Bela Shmirkin - Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1 a
Department of h
Important: If ite
any injury or ot 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Garden of Remembrance! 03/04/2012 | Clarksburg, Maryland 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Hines-Rinaldi Funeral Home. Inc. 11800 New Hampshire Ave., Silver Spring, MD 20904 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Physician/ Congestive Heart Failure Medical resulting in death) Due to (or as a consequence of) Examiner Cardiomyopathy Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine 3 To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and Coronary Artery Disease use as the buris Physician/Medical Diabetes Mellitus Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Month Pregnant at time of death Day Year signed by the at Id be detached for Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Hupertension 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed? death? Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 K Residence 6 Other (Specify) 1 Yes 2 X No ည 1 Inpatient 2 ER/Outpatient 3 DOA Completely filled in by the funeral 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28c. Injury at 28b. Time of 28d. Describe how injury occurred 5 Pending 1 X Natural 2 Accident
3 Suicide
4 Homicide Investigation 1 Yes 2 No 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical 🗴 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Certifying Nurse Practitions the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. fination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated within 2 To the I 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) D46364 March 03, 2012

State Registrar

DHMH 17 Rev 06-2011

MAR 0 6 2012

31. Date filed (Month, Day, Year)

Felix Borisovich Sokolsky, M.D., 11125 Rockville Pike, #203, Rockville, MD 20852

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 🤈 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Day Peggy 2012 Ann Zemene March 11:20 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 19541 Lorraine Terrace Washington Hagerstown 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Funeral Days Min. Director 1 🗆 M 2 🗶 F 235-48-4123 Usual Residence of Dece 80 July 9, 1931 West Virginia permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy hjury or other traumatic event, the Medical Examiner must be notified at once. 10c. City, Town or Location 10a State 10h County 10d. Inside City Limits Director 1 Yes 2 No Maryland Washington Hagerstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21742 U.S.A. 19541 Lorraine Terrace 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married 1 Yes 2 No If Yes, Give Year or Dates. 3altimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify Completed 3 Widowed 4 Divorced Specify: White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Secondary (0-12) 4 Registered Nurse Nursing Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Meigs Burton Mary Susan Winter 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Charles Zemene / Husband 19541 Lorraine Terrace Hagerstown, Maryland 21742 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Bridgeport Cemetery 03/10/2012 Bridgeport, West Virginia 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Rest Haven Funeral Chapel 1601 Pennsylvania Ave. Hagerstown Maryland 21742 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ OLOMA disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, Examiner cause. Enter Underlying Cause (Disease or injury Due to for as a consequence of, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months? Day Pregnant at time of death 2 No 1 ☐ Yes 2 L 9 ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown EREBRAL VASCULAR Were autopsy findings available prior to completion of cause of death? Acci Den 24a. Was an autopsy performed Yes 2 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 2 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: work?
1 Yes 2 No 1 Natural 5 Pending injury 2 Accident
3 Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier

A STATE OF

00066930

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2012

GPRSTOWN PENNSYLV ANIA 31. Date filed (Month egistrar's Signature

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

Registrar

(Check

only one)

29b. Signature and title of certifier

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			For State		State	of Maryla		artment of			/lental Hy	giene		
			Registrar 1. Decedent's Nam	ne (First Middl	e Last)		Ce	rtificate o	Deati	7	2. Date of De	Reg. No. 2	12	0893
	Physicia Medi		John								Month March	Day	Year	3. Time of Death
Mark	Examin				n, give street and nu			4b. City, Town		on of Death		4c. County of		
>	<u></u>		Genesis I	Multime	dical Cent		to a laborate to b	Tows		d== 0.4 l l		Bult		
	Funeral Director		218-22-182		X X M 2 □ F	7. Age (In yrs	Yrs.		Months Days Hours Min. Feb 25			1929	9. Birthp MD ^{Count}	lace (State or Foreign ry)
	land show d at	٦	Usual Residence o 10a. State	Decedent 10b. County		100.0	ity, Town or Lo	cation					14	
	Marylar 28a-f sl	Funeral Director	MD	1 '	imore	100.	, , , o , , , , , , , , , , , , , , , ,	Tows	son] "	0d. Inside City Limits 1 Yes 2XX No
	the Manager	ğ	10e. Street and Nu			**		10f. Zip Code	e			10g. Citizen of W	hat Coun	
	h with ns 23a must b	nera	969 Radcli	ffe Road								U.S.	Α.	
920	within 72 hours after death with the Maryland giene. er than "natural", or items 23a or 28a-f sho f, the Medical Examiner must be notified at	by	11. Marital Status 1 ☐ Never Mar 3 XX Widowed		ried Armed F	cedent Ever in L Forces? s 2 No ive Koreai		Was Decedent of If Yes, specify Co 1 Pes 2 XX	ıban, Mexi	can, Puerto	cify Yes or No- Rican, etc.)		, White, e	tc.
5-0	2 hours afi "natural", edical Exa	plet	(Spe		nt's Education est grade complete	d)		dent's Usual Occ		nost of worki	na	16b. Kind of Bus	iness Ind	ustry
121	vithin 72 hour piene. er than "natu the Medical	Specify: Specify:								BGE				
Maryland 21215-0036	Secondary (0-12) College (1-4 or 5+) Engineer BGE													
lary	should and h is ma	The second secon									ode)			
e, N	and 2 s Health em 27 ther tr		Phyllis St 20a. Mynyod of Dis		Daughter)	Look		adcliffe	Road	1				
Baltimore,	permit. Page 1 Department of I Important: If it any injury or o'		1 ☐ Burial 2 4 ☐ Donation	Cremation 5 Cother (\$		m State Dul	cemetery cred aney Val	sition (Name of natory or other p Ley Memor		3/24/	Date 20c. Location - City or Town, State Timonium, MD			
Bal	permi Depar Impo any ir once	21. Signature of Funeral Service tricenses Seitz Funera 3631 Falls Road Balto, MD 21211									ral Ho	ome, Inc.		
	23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) A disease or condition as Urebro Vascular Disease or condition resulting in death)									Approximate Interval Between Onset and Death				
	Examiner			r Mr. va		or as a consection		moreha	90-				2	125/2012
	ansit	edical Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury				rasa consequence of):							years
	e execuian and	al Ex	that initiated event resulting in death)	s Last	Due to	or as a consec	quence of):							1011
68760	icate be executed physician and s the burial-transit				d. <u>Co</u>	ronary	Artery	Diseas	Se				-	years
. Box 68	ath certif attending for use a		IF FEMALE: 23b. Was decedent in the past 12 I 1 Yes 2 9 Unknown	months?	1 Live	atcome of pregn Birth 2 Fe gnant at time of nown	tal death 3	Ectopic pregna Other (specify)	ncy			23d. Date Mont		y Day Year
P.O.	requires that the de been signed by the should be detached	۾	Part II. Other signif	icant condition	ns contributing to	death but not re	sulting in the u	nderlying cause	given in Pa	rt I.	23e. Did to	obacco use contrib	ute to the	cause of death?
rds	equire	eted									1 🗆 '			ably 4 🗆 Unknown
of Vital Records,	: The law r cate has b ; page 2 s	Completed				-					24a. Was a autop perfo	rmed? de	ere autops or to com ath? Yes 2	sy findings available pletion of cause of
ita	nysician: Transcribes of director, p	m l	25. Was case referre examiner? 1 ☐ Yes 2 ☐	ed to medical	Hospital:				L	eath Check				
n of V	nding Phys tth. : After this s funeral di	cate: To	27. Manner eath		28a. Date (Mor	Inpatient 2 in of injury oth, Day, Year)	28b. Time of injury	t 3 L DOA 28c. Inju	4 1	2		lence 6 Other ow injury occurred	(Specify)	
Division	al or Atte	Certificate:	3 ☐ Suicide 4 ☐ Homicide	6 Could determ	not be 28e. Place	e of Injury - At hing, etc. (Specif	ome, farm, stre	eet, factory, office		2	8f. Location (S City or Tow	treet and Number on, State)	or Rural F	oute Number,
	he Hospit in 24 hour he Funera pleted fille	Medical	(Check 2		Physician: To the baxaminer: On the ba	sis of examinatio	on and/or invest	igation in my onit	nion death	occurred at t	the time date of	nd place, and due to	the caus	o(e) and manner etated
	To t With To tl		29b. Signature and		1.2.6		10	29c. Licen	se number			29d. Date signed (/	Month, Da	y, Year)
		-	30. Name and addre	ulle L	· Kalena	70.0	U/ 0230 (Time 17	1 KO9	7104	*		march a	20,2	012
0			Michelle	E. Kale	ndekcr	1P 7700	York R	oad Ton	lson I	Marul	and 2	1204		
	Stat Registra	e r	Michelle E 31. Date filed (Month	7 2 2 20	112 Jew	Registrar's Signa	face	V		1		·		

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Marie Bigham	S 1- For State Registrar	tate of Maryland	/ Department of Certificate of		nd Mental I		20 l	2 0893	
Physician/ Medical Examiner	1. Decedent's Name (First, Midd	Marie B	igham			2. Date of Dea Month March 21	Day Year	3. Time of Death 0615 hrs	
	4a. Facility Name (if not instituti 824 West 34th Street		r)	4b. City, Town, o Baltimore	or Location of Dea		4c. County of Dea	th	
Funeral Director	5. Social Security Number 216-68-3867	6. Sex 7. A	ge (In yrs. last birthday) 56	If Under 1 Ye Months Da			, 1955 °C		
ow any	Usual Residence of Decedent 10a, State 10b, County MD N/A		10c. City, Town or Loc Baltimore	ation				10d. Inside City Limits 1 Yes 2 No	
ith the Maryland 23a or 28a-f sh potified at once al Director	10e. Street and Number 824 West 34th Str	reet		10f. Zip Code 21:	211		0g. Citizen of What Co	7111	
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23s or 28s-f show injury or other traumatic event, the Medical Examiner must be potified at once. To Be Completed by Funeral Director	1 Never Married 2 XXM	Armed Forces 1 Yes 2 If Yes, Give Year or Dates: ecify only highest grade con	P If 1 If 1 If 1 If 1 If 1 If 1 If 1 If	Yes, specify Cuba Yes 2XX No ent's Usual Occupa most of working life	on, Mexican, Puer ospecify: ation (Give kind o	to Rican, etc.)	White, etc. Specify: 16b. Kind of Business	Mhite //industry	
MD 21215-0036 d 2 should be filed within 72 hour lith and Mental Hygiene. n 27 is marked other than "natur numatic event, the Medical Exan To Be Completed	12th 17. Father's Name (First, Middle John Foster	, Last)	Hom	emaker		ne (First, Middle, 1 ia Phoebus	Own Ho	ome	
MD 212 d 2 should be lth and Menti n 27 is mark numatic even	19a. Informant's Name/Relations Harry Bigham, Sr.		824	West 34th	et and Number or Street B	Rural Route Num altimore,	nber, City or Town, Stat ${ m MD} 21211$		
Baltimore, pernit. Pages I an Department of Hea Important: If itee	20a. Method of Disposition 1 XX Burial 2 Cremation 4 Donation 5 Other S 21 Signature of Funera 3 1	pecify:	Parkwood Co	other place) emetery	3,	Date /24/12	Parkville,	MD	
Physician	3631 Falls Road Balto, MD 21211 23a. Part I. Enter the lisease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approx								
/Medical Examiner	Immediate Cause (Final disease or condition resulting in death)	A 41 1 4' -	Cardiovascular Di equence of):	sease				Between Onset and Death	
ted Insit Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a cons c.							
0, be execusionand and and and and and and and and and	UNPENDED	d AMENDED							
U = .= ○ >	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Uni	4 Pregnant at	2 F	etal death 3 Other (Specify)	Ectopic pregr	ancy	23d. Date of deliver Month	ry Day Year	
IS, P.O. I quires that the en signed by t ald be detache	Part II. Other significant condit	ions contributing to deat	h but not resulting in the	underlying cause	given in Part I.		bacco use contribute to		
ital Records, lician: The law requires certificate has been signeter, page 2 should be Be Completed	25. Was case referred to medica			26 Place	of Death (Check	autop: perfor 1 Yes	sy prior to	completion of cause of	
Division of Vital Records, P.O. tal or Attending Physician: The law requires that the sater death. In Director: After this certificate has been signed by led in by the funeral director, page 2 should be detacted in the funeral director. Be Completed by Pertification: To Be Completed by P	examiner? 1 Yes 2 No 27. Manner of Death	Hospital: 1 Inpatie 28a. Date of Inju (Month, Day, Y	ent 2 ER/Outpatier ury 28b. Time of	nt 3 DOA	lo.,	ng Home 5	Residence 6 🗹 Othe	er: Scene	
Division o Boptal or Attending 24 hours after death. Planeral Director: After and filled in by the funcal filled in by the funcal Certification:	2 Accident Invest	stigation	njury - At home, farm, stre			28f. Location (S or Town, Si		ural Route Number, City	
To the Hospita within 24 hours To the Functual completely fille	one) 2 Medical Exa	2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.							
	29b. Signature and title of certified and title of certified and address of person 30. Name and address of person		leath (Item 23a)	O.C.			29d. Date signed (Mo	mui, Day, Tear)	
	Ana Rubio MD. Ass	istant Medical Exan	niner 900 W. Bal	timore Street,	Baltimore, M	D 21223			
State Registrar	31. Date filed (Month, Day, Year)	112 Serves	r's Signatu re			OCM	E		
DHMH 17 Rev 1/2001			ORIGINA	\L		UUM	5		

DHMH 17 Rev 1/2001 OCME 2006

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND ITEM#19b, perffl, G925, 3/22/2012, WS

State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death Reg. No. 1, Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death Physician/ March 20 ay 20^Y12 12:20 A M Bonnie S. Bomke Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death BALTIMORE COCKEYSVILLE MD MASONIC HOMES Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year, Oct. 31 1 7. Age (In vrs. last birthday) **Funeral** g. Birthplace (State or Foreign Days Hours 1 M 2 XF Country) WV Director Yrs. 293-24-5327 1919 Usual Residence of Decedent ortant: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho 10a. State 10b. County 10c. City, Town or Location Funeral Director 10d. Inside City Limits Baltimore Cockeysville MD 1 ☐ Yes 2 🔀 No 10e, Street and Number 10f. Zip Code 21030 10g. Citizen of What Country? 300 International Circle USA 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Armed Forces Black, White, etc Completed by 1 Never Married 2 Married ☐ Yes 2 X No Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: white 3

▼ Widowed 4 □ Divorced Specify: 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Harford County Schools Teacher Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Isephine Cogar Leroy Stacher 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Bural Route Number, City of Town, State, Zip Code)
29 Court Dr., Joppa, MD 21065 Elaine Dodd/daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 XCremation 3 Removal from State 3/21/12 Glen Burnie, MD Atlantic Crematory 4 ☐ Donation 5 ☐ Other (Specify) any inj once, 21. Signature of Fundamental License 22. Name and Address of Facility
Lemmon Funeral Home of Dulaney Valley, Inc. Michael 8. Flagle Padonia Rd., Timonium, 23a. Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition cleas Medical resulting in death) Examiner Sequentially list conditions, Examiner if any, leading to immediate cause. Enter Underlying Due to (or as a consequence or). Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events and resulting in death) Last Due to (or as a consequence of): attending physician for use as the burial Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? Day 4 ☐ Pregnant at time of death 9 ☐ Unknown Year signed by the a 9 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ ATN, CHE, DJD, Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown should peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an s certificate has b director, page 2 s autopsy 1 Yes 2 No ☐ Yes 2 1100 25. Was case referred to medical director, Be 26. Place of Death (Check only one) examiner? 2 1 No Other: မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) this funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending of Funeral Director: Al bleted filled in by the fu Accident 1 ☐ Yes 2 ☐ No Investigation Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 \square Homicide determined City or Town, State) Medical Exertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier completed 3 🗆 within 2 Certifying Nurse Practioner. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifie 29c. License number

State Registrar

MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible.

AMEND ITEM#4a, perPHYS, G925, 3/22/2012, WS

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. . Decedent's Name (First, Middle, Last) Marianne Sullivan Bright Nate of Death Name h 19Da2012 Year 3. Time of Death 2:47 A M Physician/ Medical Facility Name (if not institution, give street and number) 2310 Rosslarie Ridge Road, Apt 206 Rosslare **Examiner** 4b. City, Town, or Location of Death **Timonium** 4c. County of Death Baltimore 12310 **Funeral** 6. Sex 7. Age (In yrs. last birthday) 79 If Under 1 Year If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) 578-42-9596 June 2, 1932 Months Davs Hours 1 🗆 M 2 🗗 Director Illinois 28a-f show 10c. City, Town or Location **Timonium** permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland notified at Director Maryland 10d. Inside City Limits Baltimore 1 🗆 Yes 2 No ō 10f. Zip Code 21043 ıral", or items 23a or Examiner must be Funeral [10g. Citizen of What Country? **United States** 12310 Rosslare Ridge Road Apt #206 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No 14. Race - American Indian, Black, White, etc. White þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify. If Yes, Give "natural" 3XXWidowed 4 ☐ Divorced Completed Specify: Year or Dates Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) the Me Elementary/Secondary (0-12) of Health and Mental Hygiene. item 27 is marked other that other traumatic event, the N College (1-4 or 5+) Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 8. Mother's Name (First, Middle, Maiden Surname)
Margaret Mary Gallen John Mark Sullivan 2 ga Informant's Name/Relationship *(Typg: Print)* Therese Garroway / Daughter 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) of Health 4515 Ashley Court, Ellicott City, Maryland, 21045 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State ± 6 1 X Burial 2 \square Cremation 3 \square Removal from State Department of Important: If any injury or once. 4 ☐ Donation 5 ☐ Other (Specify) Dulaney Valley Mem. 3/22/2012 Timonium, Maryland 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Lemmon Funeral Home, Inc. 10 W. Padonia Road, Timonium, Md 21093 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Inset and Dea Immediate Cause (Final disease or condition resulting in death) Physician/ 5 Ma Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): as the burial-transit Cause (Disease or injury and that initiated events resulting in death) Last Due to (or as a consequence of): attending physiciar Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 Yes 2 No Month Day Year 1 ☐ Yes ∠ ☐ 9 ☐ Unknown signed by the 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ page 2 should be 2 No 3 Probably 4 Unknown Completed 1 Yes peen 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an this certificate has autopsy performed? Yes 2 1 Yes within 24 hours after death.

To the Funeral Director: After this certific: completely filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 Yes 2 No Other: ည 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 28b. Time of Certificate: 28d. Describe how injury occurred 1 Natural 5 Pending Accident Investigation 1 Yes 2 No Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 3 29b. Signature and title of certification 29c. License number ma 517 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) R Bra 16500r leans Street

DHMH 17 Rev 06-2011

State Registrar 2 2

Registrar's Signati

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Robert James Physician/ Benone March 18442012 05:17 AM Medical 4a. Facility Name (if not institution, give street and number, Examiner 4b. City, Town, or Location of Death 4c. County of Death Howard County General Columbia itoward Social Security Number Funeral 7. Age (In yrs. last birthday, If Under 1 Year If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) 1 🕅 M 2 🗆 F 71 Months Days Hours Min 096-32-7925 Director une_30 New York Usual Residence of Decedent or 28a-f show Department of Health and Mental Hygiene.

Important: I frem 27 is marked other than "nature!"
any injury or other traumatic power. 10a. State 10b. County 10c. City, Town or Location Director 10d. Inside City Limits Maryland Howard Columbia 1 Yes 2 To No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 9441 Penfield Road North 21045 USA 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Armed Forces?

1 X Yes 2 No
If Yes, Give Yes, specify Cuban, Mexican, Puerto Rican, etc. Black, White, etc. ģ 1 Never Married 2XXMarried 1 ☐ Yes 2 🛣 No Specify: 3 Divorced Completed White Specify: Year or Dates. 59–1963 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Facility Maintenance National Park Service Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Salvatore Barone Rose Bonsignore 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Beverly Barone- Wife 9441 Penfield Road North, Columbia, MD 21045 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 M Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) cemetery, crematory or other place)
Meadowridge Mem. Park 03/21/2012 Elkridge, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Gary L. Kaufman F.H. 7250 Washington Blvd., Elkridge, Maryland 21075 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Congestive heart failure Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Acute Sequentially liet conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that in the desired as or iinjury that in the cause of the cause Examine Strokes that initiated events resulting in death) Last Due to (or as a consequence of) Be Completed by Physician/Medical Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death Month 1 Yes 2 L 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? - arrythmias 1 Yes 2 No 3 Probably 4 Unknown Were autopsy findings available prior to completion of cause of 24a. Was an autopsy death? Yes 2 No I or Attending Physician: I after death. Director: After this certifica 25. Was case referred to medical **Division of Vital** 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify, 1 ☐ Yes 2 🔏 No ပ 1XInpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work Accident
Suicide 1 🗌 Yes Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined Medical 1 🕱 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier (Check 2 3 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. the only one) Certifying Nurse Practioner. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifie march 18th 2012

State Registrar

DHMH 17 Rev 7/2009

30 Name and address of person who completed cause of death (Item 23a) (Type Print)

32. Registrar's Signature

ted cause of death (Item 23a) (Type Print)
10910 Witte facturent fackuray suite 202 Columbia - MD.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			1 ■ State State	of Maryland / Dep			Mental Hy	giene	10	0001		
			Registrar 1. Decedent's Name (First, Middle, Last)	Ce	ertificate of l	Death	2. Date of Dea	Reg. No.	112	11894		
	Physicia		Charles R. Blankenship), Sr.				16, 20	Year	3. Time of Death 4:00 P M		
, 200),	Medi Examii		4a. Facility Name (if not institution, give street and nu	<u> </u>	4b. City, Town, o	r Location of Death	Tiaz en	4c. County		4.00 1		
-1	,		5535 Link Avenue		Arbutu			Baltimore				
	Funeral Director		5. Social Security Number 6. Sex	7. Age (In yrs. last birthday,	Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birtl (Month, Day	h (, Year)	9. Birthp Count	lace (State or Foreign try)		
		1	215-12-4917 1 😾 M 2 □ F Usual Residence of Decedent	91 Yrs.			Oct. 7	, 1920	Mary	land		
	/land f sho	후	10a. State 10b. County	10c. City, Town or L					10	0d. Inside City Limits		
	Man 28a- notifie	Director	MD Baltimore	Arbutu	IS					1 🗆 Yes 2 🖾 No		
	ith the	ral	10e. Street and Number		10f. Zip Code			10g. Citizen of V	Vhat Count	try?		
	ath w	Funeral	5535 Link Avenue	cedent Ever in U.S. 13	. Was Decedent of H	21227	ocify Ves or No-	USA		1 0		
စ္	or ite	by F	1 Never Married 2 Married 1 Yes	Forces?	If Yes, specify Cuba	an, Mexican, Puerto	Rican, etc.)		e - America k, White, e			
003	urs af :ural", al Exa	ted	3 ☐ Widowed 4 ☐ Divorced If Yes, G Year or I		1 Yes 2 No	Specify:		Specify:	Whit	e		
15	72 hours after death with the Maryland n "natural", or items 23a or 28a-f sho ledical Examiner must be notified at	Completed	15. Decedent's Education (Specify only highest grade complete	d) (Give	edent's Usual Occup kind of work done	during most of work	ing		16b. Kind of Business/Industry			
212	within giene.		Elementary/Secondary (0-12) College O	(1-4 OF 5+)	DO NOT use retired) ersmith			Beth] Steel				
br	ent et	Be	17. Father's Name (First, Middle, Last)			18. Mother's Nam	e (First, Middle, I					
ylaı	ould be find Menta marked maric ev	2	William Albert Blankens	sip .		Katherin	ne Luttz					
Mar	shou h and 7 is rr traum		19a. Informant's Name/Relationship (Type, Print)		ling Address (Street					ode)		
e,	and 2 Healt tem 2		Karen Baker / Daughter 20a. Method of Disposition	20b. Place of Disp	Hilltop D	-						
Baltimore, Maryland 21215-0036	permit. Page 1 and 2 should be to Department of Health and Menta Important: If item 27 is marked any injury or other traumatic enonce.		1 Burial 2 ☐ Cremation 3 ☐ Removal from 4 ☐ Donation 5 ☐ Other (Specify)	m State Loudon F	ematory or other place ark	(a)	Date 22.2012	20c. Location - Baltimo				
altir	mit. P partm portar injur		21. Signature of Funeral Service Licensee		2. Name and Addres							
m	Depar Impor any ir		Sellin () fro	// N	.328 Sulph							
			23a. Part 1. Enter the disease, or complications that shock, or heart failure. List only one cause on e	caused the death. Do not en	ter the mode of dyin	g, such as cardiac o	or respiratory arre	est,		Approximate Interval Between		
Links .	Physician/		Immediate Cause (Final disease or condition	arcinon	a Du	odene	1 m			Onset and Death		
May P	Medical Examiner		resulting in death) Due to	o (or as a consequence of):						-9		
		Jer	Sequentially list conditions, b.	Or as a consequence of,	ance	7				I year,		
	ansit	ami	cause. Enter Underlying Cause (Disease or injury that initiated events	- (0		
	exectan an an arrial-tr	E		o (or as a consequence of):								
260	cate be executed physician and s the burial-transi	edical Examiner	d						\perp			
687	requires that the death certificate be executed been signed by the attending physician and should be detached for use as the burial-transit		IF FEMALE:	utcome of pregnancy								
Вох	atten affor u	Physician/M	in the past 12 months?	e Birth 2 🗌 Fetal death 3	Ctopic pregnance Other (specify)	У		23d. Dat Mor	e of deliver nth [ry Day Year		
о. В	the de	hys	9 Unknown g Unk	known								
<u>.</u>	s that gned be del	by	Part II. Other significant conditions contributing to	death but not resulting in the	underlying cause giv	en in Part I.	23e. Did tol	pacco use contri	bute to the	e cause of death?		
Records,	een si ould	Completed	Hyperten	sun			1 🗆 Y	es 2 No	3 🗌 Proba	ably 4 🗌 Unknown		
ပ္ပ	has b	mple	[—————————————————————————————————————				24a. Was a autops	sy p	rior to com	sy findings available apletion of cause of		
Ä	sician: The law is certificate has birector, page 2 s		25. Was case referred to medical				performula 1 Yes		eath?	≥ □ No		
/Ita	rsicial s certii directo	To Be	examiner?] In	Othe	ace of Death (Check	-	<i>K</i>				
of	ig Phy er this neral o		27. Manner of De th 28a. Date		f 28c. Injury	4 Nursing Ho		ence 6 L Othe w injury occurre				
O	eath. or: Aff the fu	fica	2 Accident Investigation	nth, Day, Year) injury	M Vork	Yes 2 No						
Division of Vital	or Att	Certificate:	1 Homicide determined 28e. Place	e of Injury - At home, farm, st ling, etc. (Specify)	reet, factory, office		28f. Location (St. City or Town	reet and Number	r or Rural F	Route Number,		
آ د	To the Hospital or Attending Physician: The law requires that the death certific within 24 hours after death. within 24 hours after death. or the Funeral Director. After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use a	edical (29a. Certifier 1 **Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.									
	ne Hos n 24 h ie Fur oletely	Medi	(Check 2 Medical Examiner: On the batter only one) 3 Certifying Nurse Practitione	asis of examination and/or inves	stigation, in my opinio	in death occurred at	the time date an	d place and due	to the cause	pa(e) and manner stated		
	To the		29b. Signature and title of certifier		29c. License			9d. Date signed				
			rain J. Kawpi	nem M.1)	1)-	2630	/	3/16/	12			
			30. Name and address of person who completed cau	se of death (Item 23a) (Type,	Print) ANDI	ERD	110	T1(10.4	41 4	1D2109A		
	Stat	е	31. Date filed (Month, Day Year) 32. F	A parar's Signature	· I MIL	LIV	, all	MICH	MI	10		
	Registra	ır	*** D D D D D D D		To M. J							

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decèdent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** March 19,2012 Year 4 15 p M Gertrude I. Blackwell /Medical 4a. Facility Name (If not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death Baltimore

| FUnder 1 Year | Hours | Min. | 8. Date of Birth | Pays | Hours | Min. | May 20, 1916 Genesis Long Green N/H 5. Social Security Number 242-16-9360 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Country) **Funeral** Months 95 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, it. Mindical Ermini runs be inclined a 10a. State 10b. County ed other than "natural", or items 23a or 28a-f show event, the Midical Examination must be notified at 10c. City. Town or Location 10d. Inside City Limits MD N/A Baltimore Director 1X Yes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1214 Edison Highway 21213 Completed by Funeral USA 12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☑ No 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 ☐Yes 2 ☑ If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ∐Yes 2 ∐Wio 3 Nidowed 4 Divorced Specify. SpecifBlack 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Aberdeen Proving Elementary/Secondary (0-12) 12th College (1-4or 5+) Grounds Researcher 17. Father's Name (First, Middle, Last) Be 18. Mother's Name (First, Middle, Maiden Surname) Arthur Medley Harriett Epps ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Equella Barnett/Niece 1363 Pentridge Rd. Baltimore, MD 21239 20b. Place of Disposition (Name of cemetery, crematory or other p 20a. Method of Disposition Date 20c. Location - City or Town, State 1 🖾 Burial 2 ☐ Cremation 3 ☐ Removal from State Arbutús Mém. Pk. 3/23/12 Arbutus, MD 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licer 22. Name and Address of Facility Beverly D. 22. Name and Address of Facility Beverly D. Cromartie F/S 2700 Edmondson Ave. Balto., MD 21223 23a. Party Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, whick, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Examiner S quentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine the Hospital or Attending Physician: The law requires that the death certificate be executed and Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760 attending physician for use as the buria Physician/Medical yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 3 Ectopic pregnancy in the past 12 months? 1 □Yes 2 ■No Month 4 ☐ Pregnant at time of death Dav Year 5 Other (specify) signed by the a ☐ Unknown 9 Unknown significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Ş Q otiti 01015m Be Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown s certificate has t irector, page 2 s 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No autopsy perforn 1 ☐ Yes 2 No filled in by the funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending 2 Accident investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifler (Check only

within 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral director.

State Registrar

DHMH 17 Rev 1/2001

30. Name and address of person

one

29b. Signature

who completed cause of death (Item 23a) (Type, Print) MELROSE AVE

and manner stated.

2012

29c. License number

D0047056

12-00794 Audrev Caslow

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Audrey Caslow		ertificate of Death A Death	ene Reg. No. 2012 0891						
Physician/	1: Decedent's Name (First, Middle,Last) Audrey R. Caslo	- N	Date of Death 3. Time of Death Month Day Year						
	4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death						
Funeral	Gilchrist Hospice 5. Social Security Number 6. Sex 7. Age (In yrs.	Towson last birthday) If Under 1 Year If Under 24Hrs. 8.	Date of Birth (MM/DD/YYYY) 9. Birthplace (State or						
o Director	213-14-5271 1 M 2XF 91	Months Days Hours Min.	June 18, 1920 Foreign Country Land						
6	Usual Residence of Decedent 10a, State 10b, County 10c, Cit	y, Town or Location	10d. Inside City Limits						
	MD. Baltimore H	Munt Valley	1 Yes 2 X No						
the Maryland is or 28a-f sho wiffled at once.	10e. Street and Number 1024 Hidden Moss Dr.	10f. Zip Code 21030	10g. Citizen of What Country?						
eath with the Maryland ricans 23a or 28a-f sho ust be notified at once, uneral Director	11. Marital Status 12. Was Decedent Ever in U	U.S. 13. Was Decedent of Hispanic Origin? (Specify							
er death with t	1 Never Married 2 Married Armed Forces? 1 Yes 2 No 3 Widowed 4 Divorced If Yes, Give Year	If Yes, specify Cuban, Mexican, Puerto Ricar							
ours aft atural" camine	15. Decedent's Education (Specify only highest grade completed)	Yes 2 X No specify: 16a. Decedent's Usual Occupation (Give kind of work of the control of	Specify: White done 16b. Kind of Business/Industry						
Baltimore, MD 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked rufter than "natural", or items 23s or 28s-f she injury or rufter traumatic event, the Medical Examiner must be notified at sonce To Be Completed by Funeral Director	Elementary/Secondary (0-12) College (1-4 or 5+)	during most of working life. DO NOT use retired) Homemaker	Own Home						
5-00 lled with Hygien Inther in Me	17. Father's Name (First, Middle, Last)		t, Middle, Maiden Surname)						
2121 ould be fi ould be fi s marked ite event,	Nicholas Reus 19a. Informant's Name/Relationship (Type, Print)	Marie I 19b. Mailing Address (Street and Number or Rural I	Hecht Route Number City or Town State Zip Code)						
MD dd 2 sho	Sharon Caslow/ Daughter	1024 Hidden Moss Dr. H	Hunt Valley, MD. 21030						
Ore, ges lar tof Heg. If the transfer t	1 X Burial 2 Cremation 3 Removal from State	Place of Disposition (Name of cemetery, crematory or other place)							
altim mit. Pa partmen portant ury or 1	4 Donation 5 Other Specify: M 21. Signature of Funeral Service Licens	oreland Memorial Pk 2-1-1							
	23a. Part I. Enter the disease, or complications that caused the deat	TODO TOTK KG. TOM	VSOIL, MD. ZIZU4						
Physician /Medical ≟xaminer	failure. List only one cause on each line. Acute Ren. Immediate Cause (Final disease a. and poor Nutr	al Failure complicating Hy	rpoglycemia Between Onset and Death						
Examiner	or condition resulting in death) Due to (or as a consequence of):								
iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause	uty.							
ted Insit	(Disease or injury that initiated events resulting in death) Last Due to (or as a consequence	of):							
execuian and al-tra	MENDED 23a,27,28a-f,per me,g926 4-10-12 sm								
1760, ficate be g physici the buri	IF FEMALE: 23c. If yes, outcome of precable Was decedent pregnant in the	gnancy	23d. Date of delivery						
Box 6876 ne death certificate the attending phy had for use as the Physician/M	past 12 months?	2 Fetal death 3 Ectopic pregnancy eath 5 Other (Specify)	Month Day Year						
च क्रामा		resulting in the underlying cause given in Part I.	23e. Did tobacco use contribute to the cause of death?						
ords, P.O. w requires that the street of the detack should be detack pletted by Pletted by P			1 Yes 2 No 3 Probably 4 V Unknown						
of Vital Records, sg.Physician: The law require. ther this certificate has been signeral director, page 2 should be n: To Be Completed			24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death?						
tal Rections The certificate ector, page	25. Was case referred to medical	26.Place of Death (Check only or	Yes 2 No 1 Yes 2 No						
Vital hysician: this certiful director,	examiner? 1 Yes 2 No Hospital: 1 Inpatient 2	1Other —	ne 5 Residence 6 Other:						
	27. Manner of Death 1 Natural 5 Pending 28a. Date of Injury (Month, Day, Year)	1 Yes 2 No Sub	Describe how injury occurred Dject neglected						
Division o ital or Attending ans after death. Ited in byte for after leed in by the france	2 Accident Investigation I Q 1-17-12	nome, farm, street, factory, office building, etc. 28f. L	ocation (Street and Number or Rural Route Number, City						
물질을 달 아	29a. Certifier	Sidence Coo	or Town, State) 1024 Hidden Moss Dr. ckeysville,MD.						
To the He within 24 within 24 Confiered electron	(Check only	dge, death occurred at the time, date and place, and due to and/or investigation, in my opinion, death occurred at the ti	o the cause(s) and manner as stated. ime, date and place, and due to the cause(s)						
F 3F 3 E	29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)						
	30. Name and address of person who completed cause of death (Iten	O.C.M.E.	January 28, 2012						
	Zabiullah Ali, M.D. Assistant Medical Examiner	900 W. Baltimore Street, Baltimore, MD	21223						
State Registrar	31. Date filed (Monte EB 2 7 2012 32. egistrar's Signat	3. parla							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 71027 M 2012 Medical Facility Name (if not institution, give street and number, **Examiner** 4c. County of Death SAUTIMORE INASHINGTON MEDICAL AHNE **JIE Funeral** Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 1 M 2 X F Months Days (Month, Day, Year) Director Yrs. Spekmber 11 Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City, Town or Location Director 10d. Inside City Limits event, the Medical Examiner must be notified Anne Maryland evern 1 🗌 Yes 2 🗷 No 10e. Street and Number ō 10f. Zip Code 10g. Citizen of What Country? Funeral 23a Evesboro or items 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, þ 1 Never Married 2 Married 1 Yes 2
If Yes, Give
Year or Dates Black, White, etc "natural", 1 ☐ Yes 2 X No Specify Completed 3 Midowed 4 Divorced Specify: 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) and Mental Hygiene. is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Malden Surname, 2 traumatic 0 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If item 27 is any injury or other tra Darrin farkton St. Fort Washington 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State cemetery, crematory or other place, Roosevelt Memorial 2012 4 Donation 5 Other (Specify) Signature of Funeral Service Licenses B Arlington, Va. 22206 South Shirlington Read 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line Interval Between Onset and Death Immediate Cause (Final Physician/ DEMENT disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions. Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): attending physician and for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 Fetal death 3 ☐ Ectopic pregnancy5 ☐ Other (specify) in the past 12 months?
1 ☐ Yes 2 ☑ No Pregnant at time of death Day Month Year 1 Yes 2 9 Unknown n signed by the a lid be detached f Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown completed filled in by the funeral director, page 2 should peen . Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an within 24 hours after death.

To the Funeral Director: After this certificate has autopsy performed? Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital 2 No ျှ 1 Tyes Other: 1 Inpatient 2 🗆 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 1 Natural Certificate: 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) 5 Pending Accident 1 Yes 2 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Destroying Physician to the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one and title of certifie 29d. Date signed (Month, Dav. Year) ge and address of person who completed cause of death (Item 23a) (Type, Print) Glen Burnie Drive

State Registrar 31. Date filed (Month, Day,

32. Registrar's Sig

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

	For State Registrar	State of Marylar		artment of F		d Mental Hy	giene Reg. No. ? (112	08946
Physician/	1. Decedent's Name (First, Middle) Jung Sook Cheor					2. Date of De	eath 17, ^{Day} 201	2 Year	3. Time of Death 11:00 PM
Medical Examiner	4 E 10 M 27 - 11 10 11	give street and number)		4b. City, Town, or Ox	Location of De	eath	4c. Coun	tv of Death	orge's
Funeral Director	5. Social Security Number N/A	6. Sex 7. Age (In yrs.	last birthday) Yrs.	If Under 1 Year Months Days 8 16	If Under 24 H Hours N	lin. (Month, Da	ıy, Year)	Coun	
1	Usual Residence of Decedent		ty, Town or Lo			July 1	, 1923		Orea Od. Inside City Limits
or 28a-f sho	Maryland Howa		11icot						1 Yes 2 No
leath with the litems 23a or 2 let must be no		Court Drive		10f. Zip Code 21042			10g. Citizen o	f What Cour Korea	itry? a
, r.E	1 ☐ Never Married 2 ☐ Marr	12. Was Decedent Ever in U. Armed Forces? 1 Yes 2 N No If Yes, Give Year or Dates.		Was Decedent of Hi If Yes, specify Cuba 1 ☐ Yes 2 🛣 No		(Specify Yes or No- erto Rican, etc.)		ace - Americ ack, White, e fy: Asia	etc.
Maryland 21215-0036 2 should be filed within 72 hours after th and Mental Hygiene. 27 is marked other than "natural", o rtraumatic event, the Medical Exam To Be Completed by	15. Deceder (Specify only higher Elementary/Secondary (0-12)	t's Education t grade completed) 2 College (1-4 or 5+)	(Give life. D	dent's Usual Occup kind of work done o O NOT use retired)	luring most of t	working	16b. Kind of		
d 21 led with Hygien other the			Scho	ool Teach		Name (First, Middle,	Maiden Surnar	Educa	TTOII
ylan ild be fil Mental Mental narked natic ev		ong			Soc	on Nam Kir	n		
Mar 12 shou 1th and 27 is m	19a. Informant's Name/Relationsh Young Min Chan					Dr., E11			
Baltimore, sermit. Page 1 and Department of Hea Important: If item any injury or other once.	20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation	20b.	Place of Dispo cemetery, crer	sition (Name of matory or other plac	e)	Date	20c. Location	n - City or To	wn, State
Iltim	4 ☐ Donation 5 ☐ Other (S 21. Signature of Funeral Service L	pecify) Me				3/21/2012 Gary L. Ka			
Den Den Den any any any any any any any any any an	May 1	J. Brokam	<u>7</u> 7	250 Washi	ngton	Blvd., E	lkridge		land 21075
	23a. Part 1. Enter the disease, or shock, or heart failure. List o Immediate Cause (Final	•			g, such as card	liac or respiratory ar	rrest,		Approximate Interval Between Onset and Death
Physician/ Medical	disease or condition resulting in death)	a. Myocardia Due to (or as a consec		rction			-500	-	
Examiner	Sequentially list conditions,	b. Chronic r		ailure					·
xecuted and al-transit	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a consec	querice or).						
siciar siciar buri		Due to (or as a consected d.	uence of):						
certificate nding phy use as the	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregn					23d. [Date of delive	ery
al or Attending Physician: The law requires that the death certificate I is after death. In law care and in sortificate has been signed by the attending physical in by the funeral director, page 2 should be detached for use as the Certificate: To Be Completed by Physician/Medic	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	1 ☐ Live Birth 2 ☐ Fet 4 ☐ Pregnant at time of g ☐ Unknown		Other (specify)	у			Nonth	Day Year
es that the igned by be deta	Part II. Other significant condition	ns contributing to death but not re	sulting in the u	inderlying cause giv	en in Part I.				ne cause of death?
The law require cate has been single page 2 should						24a. Was	an 24b	. Were autor	osy findings available mpletion of cause of
sician: The law recertificate has bilirector, page 2 s							psy ormed? 2 X No	death?	
sician: certification	25. Was case referred to medical examiner?	Hospital: 1 ☐ Inpatient 2 ☐	ER/Outpatie	_ Othe		Check only one)	dence 6X 0	ssite	d Living
To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending phy completely filled in by the funeral director, page 2 should be detached for use as the Medical Certificate: To Be Completed by Physician/Med		28a. Date of injury (Month, Day, Year)	28b. Time of injury	28c. Injury work	/ at		how injury occu		-
or Attending P safter death. Director: After t d in by the funer. Certificate:		ot be 290 Place of Injuny - At h		eet, factory, office		28f. Location (City or Tou	Street and Num wn, State)	ber or Rural	Route Number,
he Hospita in 24 hours he Funeral spletely fille	29a. Certifier 1 Certifying (Check 2 Medical E	Physician: To the best of my know caminer: On the basis of examination	on and/or inves	tigation, in my opinic	n, death occurr	red at the time, date	and place, and c	lue to the cau	use(s) and manner stated
To the within To the comp	20h Signature and title of certifier	n bh mg	ny monego	29c. License		la piace, and due to	29d. Date sign		
•	30. Name and address of person v		n 23a\ /Ti-na - I	D180	92		03-	14-2	0/2
	Dr. Ihn Loh,	MD, 5107 Silver	Hill R	d., Suitl	Land, M	D 20746			
State Registrar	31. Date filed (Month, Day, Year) MAR 2 2	32. Degistrar's Signa	ature	arked					
DHMH 17 Rev 06-201			7						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) Physician/ WAR Medical 4a. Facility Name (if not institution, give street and number) Examiner 4c. County of Death 509 Annabel Avenue Baltimore N/A If Under 1 Year | If Under 24 Hrs.
Months Days Hours Min. 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 8. Date of Birth 217 40 3545 Months Days (Month, Day, Year) **Director** 1 🗷 M 2 🗆 F 68 Yrs 01/15/1944 Maryland Usual Residence of Decedent "natural", or items 23a or 28a-f show 10c. City, Town or Location the Medical Examiner must be notified at 10d. Inside City Limits Director Maryland Baltimore N/A 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 509 Annabel Avenue 21225 U.S. within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12 Was Decedent Ever in U.S. 14. Race - American Indian. Armed Force Black, White, etc. þ 1 Never Married 2 X Married 1 Yes 2 X No Maryland 21215-0036 1 Yes 2 No Specify If Yes Give White Specify 3 Widowed 4 Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. Baltimore City 1 year Elementary/Secondary (0-12) Policeman Policeman Police Department Be 17, Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) pe (George Cummings Mary Roloska t. Page 1 and 2 should be tment of Health and Men rtant: If item 27 is marke ijury or other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Patricia Cummings / wife 509 Annabel Avenue Baltimore, Maryland 21225 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State 03/21/2012 Important 4 Donation 5 Other (Specify) Holy Cross Cemetery Baltimore, Maryland any injury Signature of F neral Service 22. Name and Address of Facility Gonce Funeral Service, P.A. 4001 Ritchie Highway Baltimore, Maryland 21225 Enter the disease, or complications that dused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause of Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Medical Due to (or as a consequence **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Uncerlying Physician/Medical Examiner Due to (or as a consequence of): Cause (Disease or injury use as the burial-trar and that initiated events resulting in death) Last Due to (or as a consequence of): attending physician that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Pregnant at time of death 5 Other (specify) Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by The law requires 1 Yes 2 No 3 Probably 4 Onknown Completed Were autopsy findings available prior to completion of cause of death? 24a, Was an To the Hospital or Attending Physician: The law within 24 hours after death.

To the Funeral Director: After this certificate has! autonsy 2 🗌 No Yes 1 Yes Be 25. Was case referred to redical 26. Place of Death (Check only one) 1 Yes Certificate: To 1 Inpatient 2 ER/Outpatient 3 DOA filled in by the funeral 27. Manne Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred atural injury 5 Pending 1 Yes 2 No Accident Investigation Suicide Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, ☐ Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

100

Registrar

only one) 29b. Signature ar

address of pe

eted cause of death (Item 23a) (Type

3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

9c. License number

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 08948 State
Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death March Physician/ 2012 20 3:16A.™ Cieslak Frances Μ. Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Harford 920 Bergen Court Bel Air 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth
Jan. 15, 1930 9. Birthplace (State or Foreign **Funeral** Months Days Hours Min Maryland **Director** 212-26-1839 1 ☐ M 2🛣 F 82 Yrs. show or 28a-f show notified at 10c. City, Town or Location 10d. Inside City Limits Director MD. Harford Bel Air 1 Yes 2 No 10e. Street and Number 10f. Zip Code ō 10g. Citizen of What Country? ms 23a or must be r Funeral 21014 -6972 1007 Barrymore Road U.S.A. giene. ter than "natural", or items t, the Medical Examiner mu 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married within 72 hours after 2 X No Yes Maryland 21215-0036 If Yes, Give Year or Dates 3 Widowed 4 □ Divorced 1 Yes 2 No Specify. Specify: Completed White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) permit, Page 1 and 2 should be filed wit. Department of Health and Mental Hygier Important: If Item 27 is marked other transition any injury or other traumatic event, the ODCE. d Hyg. 12th Home Maker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Frank Getek Josephine Blachowicz 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code Linda Martin / Daughter |1007 Barrymore Road Bel Air, Md. 21014 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State March 1 Durial 2 Cremation 3 Removal from State Bayview Crematory 21, 2012 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 933 Signature of cameral, ervice Licensee 22. Name and Address of Facility Kaczorowski Funeral Home, PA 1201 Dundalk Avenue Baltimore, Md. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Amyatrophic disease or condition Medical resulting in death) s a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): and burial-trar that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Physician/Medical death certificate be Division of Vital Records, P.O. Box 68760 the IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Pregnant at time of death Day Year 1 Yes 24 g Unknown ed by the a g Unknown Hospital or Attending Physician: The law requires that the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has performe certificate Yes 2 No 2 🗌 No 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner' son s Home Hospital Other: 4 Nursing Home 5 Residence 6 5 Other (Specify) 2**X** No 1 Yes P 1 Inpatient 2 ER/Outpatient 3 DOA After this 27. Manner of Death 28a. Date of injury 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending (Month, Day, Year) work?
1 Yes 2 No n 24 hours after the Funeral Director: After the Funeral Director of the fundately filled in by the fu Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Critifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 🗌 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Sia March 20, 2012

Registrar DHMH 17 Rev 06-2011

State

Dr

MAR 2 2 2012

fleishman,M.D.

32. Registrar's Si

ishman, M.D. 9000 Franklin Square Drive Rosedale, Md21237

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Ruth Virginia Defassio ARCA 12 Medical 4a Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death County of Death JUSEPH MEDICAL 8. Date of Birth (Month, Day, Year) 7. Age (In vrs. last birthday) If Unde Birthplace (State or Foreign Country) **Funeral** Months Min 192-14-0337 Director 1 □ M 2 🕱 F 89 March 8. 1923 Pennsylvania Usual Residence of Decede 28a-f show 10a. State with the Maryland at 10c. City, Town or Location 10d. Inside City Limits Director notified MD. Baltimore Sparks 1 Yes 2 X No 10e. Street and Number 10f. Zip Code ō 10g, Citizen of What Country? ems 23a or r must be r Funeral 19 Rainflower Path #302 21152 USA items permit. Page 1 and 2 should be filed within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, "natural", or ite Armed Forces? Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: Completed 3 X Widowed 4 Divorced Specify: White er than "natur , the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life, DO NOT use retired) Elementary/Secondary (0-12) 12 College (1-4 or 5+) of Health and Mental Hygiene fitem 27 is marked other the r other traumatic event, the Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည William Jacob Troutman Hazel Hadessa Porter 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Andrea Ingham/ Daughter 19 Rainflower Path #302 Sparks, MD. 21152 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Department of himportant: If ite any injury or other cemetery, crematory or other place) 1X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) Dulaney Valley Mem. 3-23-12 Timonium, MD. ^{22. N}Ruck ^ATowson Funeral Home, 1050 York Rd. Towson, MD. 21. Signature of uneral 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate terval Between Immediate Cause (Final Onset and Death Physician disease or condition resulting in death) Medical Due to (or as a consequence of Examiner academically list exception as Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Cause (Disease or injury burial-tran and that initiated events resulting in death) Last Due to (or as a consequence of): been signed by the attending physician should be detached for use as the buria Physician/Medical Division of Vital Records, P.O. Box 68760 use as the IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) for in the past 12 months?
1 Yes 2 No Pregnant at time of death Month Day Vear Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

ATRIAL FIBRILLATION 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown director, page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an After this certificate has perform 1 ☐ Yes 2 ☐ No 25. Was case referred to medica Be 26. Place of Death (Check only one) examiner? Hospital: Other: ဂ္ 1 🗌 Yes 2 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) Manner of Death 28b. Time of Certificate: 28c. Injury at 1 Natural 2 Acciden injury 5 Pending work? 1 ☐ Yes 2 ☐ No death. Accident Investigation 6 Could not be 3 Suicide 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined

Hospital or Attending Physician: The law requires that the death certificate be completely filled in by the funeral 24 hours after death Funeral Director: Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 within 2 To the I only one 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year, mo Name and address of person who completed cause of death (Item 23a) (Type, Print) OSLER DRIVE TOWSON, MARYLAND 21204 31. Date filed (Month, Day, 2 2 State Registrar DHMH 17 Rev 06-2011 ORIGINAL

ERCOLANO PASQUALE

2012

Division of Vital Records,

the Hospital or Attending within 24 hours a

To the Funeral I

completely filled

JUSTINE PREIS, CRNP

Could not be

determined

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29d. Date signed (Month, Day, Year) 03-21-2012

28f. Location (Street and Number or Rural Route Number,

City or Town, State)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

TIMONIUM, MD 21093 2300 DULANEY VALLEY ROAD

Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

State Registrar

Medical

29b. Signature and title of certifier

Suicide

4 Homicide

29a. Certifier

(Check

		amend #5 Pe	se Type or Print in r FH G925 3/22 State of Mary	in Black Ir 2 /2012 Ji land / Depa	ndelible In artment of l	k. Ensure . Health and	All Copie Mental Hy	e s Are Le /giene	gible.	
-		State Registrar			tificate of L			Reg. No. 🤈	0 2	08951
Physici Med		1. Decedent's Name (First, Middle, Will ma		nes			2. Date of De Month	Day	Year C /2	3. Time of Death
Exami		4a. Facility Name (if not institution,	Nursing (ex	nter	4b. City, Town, o	r Location of Deatl	1	4c. Coun	ty of Death	
Funera Director				yrs. last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da		9. Birthpla Country	sce (State or Foreign
ne Maryland or 28a-f show notified at	Funeral Director	10a. State 10b. County	100	c. City, Town or Lo	Baltimon	ce	<u>.</u>		100	d. Inside City Limits
with the M 23a or 2 st be no	eral Di	10e. Street and Number 832 Brooks Lar	ne		10f. Zip Code 21217			10g. Citizen o		y?
nd 21215-0036 filed within 72 hours after death with the Maryland al Hygiene. 1 other than "natural", or items 23a or 28a-f sho went, the Medical Examiner must be notified at	þ	11. Marital Status 1 □ Never Married 2 □ Marrie 3 ☑ Widowed 4 □ Divorced	12. Was Decedent Ever in Armed Forces?		Was Decedent of H f Yes, specify Cuba	an, Mexican, Puert	pecify Yes or No o Rican, etc.)	14. Ra	ace - Americar ack, White, etc	Э.
21215-0036 within 72 hours affer giene. er than "natural", o er the Medical Exam	Be Completed	15. Decedent (Specify only highes Elementary/Secondary (0-12)	's Education	(Give	dent's Usual Occup kind of work done o O NOT use retired)	during most of wor	king	16b. Kind of	Business/Indu	
212 ad withii Hygiene Ather th	န္တန္	9 17. Father's Name (First, Middle, La		cook	/waitres	S 18. Mother's Nar	ne (First Middle		ood ne) unk	
Maryland 2 should be filed Ith and Mental Hy 27 is marked out	101	Chamen Arı					Englis	sh 		
		19a. Informant's Name/Relationshi Dorothy Robinso			ng Address (Street Edmonds					
Baltimore, I bernit. Page 1 and 2 beatment of Healt mportant: If item 2 my injury or other noe.		20a. Method of Disposition 1 ★ Burial 2 □ Cremation 4 □ Donation 5 □ Other (Sp	3 Removal from State		sition (Name of natory or other place		Date 27-12	20c. Location	City or Tow	n, State
Baltimors permit. Page 1: Department of B Important: If its any injury or of		21. Signature of Funeral Service Lic		22	Name and Addre	ss of Facility Jar	nes A. M	forton 8	sons	F.H.,INC
Physician/ Medica		23a. Part 1. Enter the disease, or c shock, or heart failure. List on Immediate Cause (Final disease or condition resulting in death)					or respiratory a	rrest,		Approximate nterval Between Onset and Death
Examiner		Sequentially list conditions, if any, leading to immediate	b. Due to (or as a con	ic Kid	ney D.	islase				
be executed sician and burial-transit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c. hrvac) en oo	rage d	ue-to			
60 ate be e physicial the buri	dical		d. hype	Hersin						
ords, P.O. Box 68760 requires that the death certificate be exbeen signed by the attending physician should be detached for use as the buria	Completed by Physician/Medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ Wo 9 □ Unknown	23c. If yes, outcome of professional 2	Fetal death 3 L	Ectopic pregnand Other (specify)	су			ate of delivery	/ ay Year
signed by	d by Ph	Part II. Other significant condition	1	t resulting in the u		ven in Part I.				cause of death?
Division of Vital Records, P.O. alor Attending Physician: The law requires that the strend cleath. In Director: After this certificate has been signed by the dineral director, page 2 should be detach	mplete	Early	Dementa				24a. Was	an 24b	. Were autops prior to comp death?	y findings available pletion of cause of
f Vital Recc Physician: The law this certificate has	Be Co	25. Was case referred to medical examiner?				lace of Death (Che		2 No	1 Yes 2	∐ No
of Vit	은	1 Yes 2 No	28a. Date of injury	2 ER/Outpatier 28b. Time of	28c, Injur	4 LIL Mursing F y at	lome 5 Resi	idence 6 Ot		
Division of Vital To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifical completely filed in by the funeral director,	Certificate:	1 Natural 5 Pending 2 Accident Investiga 3 Suicide 6 Could n 4 Homicide determin	ation of be	At home, farm, stre		Yes 2 No	28f. Location (Street and Num	ber or Rural R	oute Number,
Div pital or ours afte eral Dir filled in	cal Ce		Physician: To the best of my k		occurred at the time	e date and place	City or To		oner as stated	
the Hos nin 24 hr the Fun tpletely	Medical	(Check 2 Medical Exonly one) 3 Certifying	aminer: On the basis of examin Nurse Practitioner: To the bes	nation and/or invest	tigation, in my opinion death occurred at	on, death occurred the time, date and p	at the time, date	and place, and d the cause(s) and	manner as sta	e(s) and manner stated. ted.
with Volume		29b. Signature and title of certifier	2	MD	29c. License	i 464		29d. Date sign	ed (Month, Da	y, Year)
		30. Name and address of person w	ho completed cause of death	(Item 23a) (Type, F	Print) FUTAL	NST C	ite zno	BALTIA	DE M	021201
Sta		31. Date filed (Month, Day, Year)	32. Egistrar's S	ignature.	ald		508	011-1119		0.001
Regist	rar	MAD 2 2	/11/2 / Beauty	13. 140	***					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Lvia Kiwakowski Year **Physician** 0440 A M 1avch 2012 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Johns Hopkins Bayview Medical Center **Baltimore** Social Security Number if Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** 1 M 2 TyF Days Hours July 16, 1929 216-24-8081 82 Maryland Director Usual Residence of Decedent 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits 28a-f show Examiner must be notified at Director 1 ☐ Yes 2 ☐ No Md. Baltimore City e filed within 72 hours after death with the Nal Hygiene.

other than "natural", or items 23a or 28a. 10e. Street and Number 10f. Zip-Code 10g. Citizen of What Country? 1024 South Decker Avenue, #302 21224 U.S.A. Funeral 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Armed Forces? 1 Never Married 2 Married Yes Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify If Yes, Give Specify: 3 X Widowed 4 Divorced White Year or Dates Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Medical 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) the Home Maker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Pages 1 and 2 should be file Department of Health and Mental Hy, Important: If iten 27 is marked othe any injury or other traumatic event, once. Be Anthony Lesniewski Josephine Milecka 19a. Informant's Name/Relationship *(Type. Print*Nephew 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Stephen Lesniewski, Jr. 8906 Mayflower Road Rosedale, Maryland21237 20a. Method of Disposition 20b. Place of Disposition (Name of Sampley drentage) 20c. Location - City or Town, State Mareh 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 21, 2012Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) of Mary 22. Name and Address of Facility aczorowski Funeral Home, PA 21. Signature of Funeral Sanice Linesee M00933 Robert 1201 Dundalk Avenue Baltimore, Md. 21222 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Stroke **Physician** disease or condition resulting in death) /Medical Examiner onavy Sequentially list conditions if any, budget to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner The law requires that the death certificate be executed physician and as the burial-tran Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical as IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death Live birth 3 Ectopic pregnancy in the past 12 months? Month Day Year Pregnant at time of death 5 Other (specify) 2 🔀 No 9 ☐ Unknown the 9 Unknown by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 🗌 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed has 2 N/Nc 1 Tes 2 🗌 No certificate 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: Other: 4 \square Nursing Home 5 \square Residence 6 \square Other (Specify) 1 ☐ Yes 2 ☐ No 1 X Inpatient 2 ER/Outpatient 3 DOA 2 this funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: or Attending Natural 5 Pending investigation Injury within 24 hours after death.

To the Funeral Director: Aft completely filled in by the fu death. 2 Accident 1 Yes 2 No 6 Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide

Hospital

State Registrar

31. Date filed (Month, Day, Year,

29b. Signature and title of certifier

29a. Certifier

one)

(check only

Medical

MAR 2 2 2012



30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

4940 Eastern Avenue, Baltimore, MD, 21224

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ MARCH 17 20^{Year}2 WILLIAM **JAMES** McDONALD 4:20 PM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death MEDSTAR GOOD SAMARITAN HOSPITAI BALTIMORE If Under 1 Year | If Under 24 Hrs Social Security Number 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days Months MAR. 22, 1940NORTH CAROLIN 1 XM 2 - F 245-54-7888 71 **Director** Usual Residence of Decedent ems 23a or 28a-f show r must be notified at 28a-f sho 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD 1√ Yes 2 No BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 6613 FAIR OAKS **AVENUE** 21214 UNITED STATES Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian Examiner Armed Forces?

1 Yes 2 No Black, White, etc. ò þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Yes, Give 1 ☐ Yes 2 XNo Specify: BLACK Specify: Completed 3 Widowed 4 X Divorced Year or Dates Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working al Hygiene. life. DO NOT use retired) $\overset{\text{Elementary/Seconday (0-12)}}{12\,t\,h}$ College (1-4 or 5+) the CRANE OPERATOR AMTRAK other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame, ည DAVID McMILLAN ROSIE McDONALD and is m 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 IAMARA McDONALD/DAUGHTER FAIR OAKS AVENUE BALTIMORE MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date ō 1 XBurial 2 Cremation 3 Removal from State Department of Important: If any injury or DRUID RIDGE CEM. 3/26/12 4 ☐ Donation 5 ☐ Other (Specify) BALTIMORE, MD 21. Si matu/ of Funeral Servic 22. Name and Address of Facility CAPITOL MORTUARY DC 20002 MARYLAND AVE NE WASHINGTON Do not enter the mode of dying, such as cardiac or respiratory arrest, 23a. Part 1. Enter the disease, complications that caused the death only one cause on each line. Approximate Interval Betwee shock, or heart failure List Immediate Cause (Final Onset and Death Ph_sician/ SHOCK disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** MULTIORGAN FAILURE Sequentially list conditions, it any, leading to immediate cause. Enter Underlying Examine sician and burial-transit Cause (Disease or iinjury that initiated events SEPSIS Due to (or as a consequence of) resulting in death) Last attending physician for use as the buria Physician/Medical LUNG CANCER Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Month Day 2 No certificate has been signed by the a rector, page 2 should be detached 9 Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 X Unknown BRAIN METASTASIS 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autonsv 1 Yes 2X No Yes 2 XN 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 2**X** No ၉ 1 Tes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify, Date of injury 27. Manner of Death 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred (Month, Day, Year) work?
1 Yes 2 No injury X Natural 5 Pending s after death.

I Director: Aft
d in by the fur M 2 Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, filled in by 4 Homicide determined Hospital To the Hospital within 24 hours To the Funeral I Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier R P 5000 MARCH 17 2012

State Registrar

DHMH 17 Rev 7/2009

LOCH RAVEN BLVD, BALTIMORE,

MD 21239

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

5601

GUMEET SARAI

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ $201^{\circ}2$ 3:15p M Thomas Nowicki March 1 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 6718 Danville Avenue Baltimore If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days Dec 14, 1932 Maryland 215 - 28 - 6950 Usual Residence of Decede 79 Director 1 ▼M 2 □ F shov 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director notified Md. Baltimore City 1 Yes 2 □ No 28a-f 10e. Street and Number 10f. Zip Code ō 10g. Citizen of What Country? must be r Funeral 21222 6718 Danville Avenue U.S.A. ıral", or items 2 | Examiner mus 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Completed by 1 Never Married 2 Married 1 Yes If Yes, Give 2 No Baltimore, Maryland 21215-0036 1 Yes 2 XNo Specify: f Health and Mental Hygiene.
item 27 is marked other than "natural",
other traumatic event, the Medical Exa Specify: 3 Widowed 4 Divorced White Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 12th Maintainance Western Electric Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Cecelia Winiecki Michael Nowicki 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code Beverly Annunziata-Daughter 405 Timber Lane Joppa, Maryland 21085 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Mareh Department of Important: If it any injury or o once. ☐ Burial 2x Cremation 3 ☐ Removal from State Bayview CRematory 26,2012 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) M00933Signature of Funeral Service Licensee 22. Name and Address of Facility Kaczorowski Funeral Home, PA Dundalk Avenue Baltimore, MD 21222 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Ph_sician/ disease or condition resulting in death) mocay of Al Medical Due to (or as a consequence of): **Examiner** wellite 20 years beter Sequentially list conditions. if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): physician and s the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ctopic pregnancy
5 Other (specify) in the past 12 months?
1 Yes 2 No Day Pregnant at time of death 1 Yes 2 2 9 Unknown g | Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an within 24 hours after death.

To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2 autopsy Hospital or Attending Physician: The 1 ☐ Yes 2 ☐ No ☐ Yes 2 💢 No 25. Was case referred to medical 26. Place of Death (Check only one) Be Hospital 1 🗌 Yes 2 🗶 No Other: 1 Inpatient 2 ER/Outpatient 3 DOA မ 4 Nursing Home 5 X Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 28b. Time of Certificate: 28d. Describe how injury occurred iniury 1 X Natural 5 Pending 1 Yes 2 No ☐ Accident Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined Medical 1 💆 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier (Check 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and ti 29c. License number 29d. Date signed (Month, Day, Year) MA D 53445 no March 16,2012 ss of person who completed cause of death (Item 23a) (Type, Print) 7600 Osler Drive 30. Name and a

DHMH 17 Rev 06-2011

State Registrar Robert

31. Date filed (Month, Day, Year)

Thomson Turner, M.D.

Towson, MD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Gregory Parker State of Maryland / Department of Health and Mental Hygiene 2 08955 1- For State Certificate of Death Reg. No Registrar 1. Decedent's Name (First, Middle Last) 2. Date of Death 3. Time of Death Physician/ Month Day March 16, 2012 **Medical Examiner** GREGORY TARKER 1632 hrs 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Johns Hopkins Hospital Baltimore 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or Funeral Director 217-70-0201 Country) 1 X M 2 F Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No BATIMORE MDDirector 10g. Citizen of What Country? 10e Street and Number 5607 BIDDISON HVENUE 21206 Funeral 11. Marital Status 12. Was Decedent Ever in U.S 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married Yes Specify: BLACK Pages 1 and 2 should be filed within 72 hours after of ment of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", of or other traumatic event, the Medical Examiner is or other traumatic event, the Medical Examiner is 4 Divorced If Yes, Give Year 1 Yes 2 No specify: 3 Widowed <u>۾</u> 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Completed Elementary/Secondary (0-12) College (1-4 or 5+) TUBLIC Works DEPT OF Baltimore, MD 21215-0036 TRUCK DRIVER 12 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) BERTHA JOHNSON WILLIS E. PARKER (Street and Number or Rural Route Number, City or Town, State, Zip Code) AVE. BALTO, MD. 21206 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State BACTIMORE, MD KING MEMORIALYARK 124/12 4 Donation 5 Other Specify VANGHN GREENE FUNGRALSUS 21. Signature of Funeral Service Licen BALTO, MD. 212/2 e, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear **Physician** Between Onset and failure. List only one cause on each line Medical Death a Multiple Gunshot Wounds Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last attending physician and or use as the burial - tran Physician/Medical UNPENDED AMENDED the Hospital or Attending Physician: The law requires that the death certificate be Box 68760, IF FEMALE: 23c. If yes, outcome of pregnancy 23d Date of delivery 23b. Was decedent pregnant in the 1 Live birth 2 Fetal death 3 Ectopic pregnancy Month Day Year past 12 months? Pregnant at time of death Other (Specify) 1 Yes 2 No 9 Unknown 9 Unknown ed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 Yes 2 ✓ No 3 Probably 4 Unknown ۵. Completed 24b. Were autopsy findings available 24a. Was an prior to completion of cause of autopsy certificate has b rector, page 2 sh performed? death? ✔ Yes 2 No 1 Yes 2 No 25. Was case referred to medical 26.Place of Death (Check only one) Division of Vital Be Hospital: 1 Inpatient 2 V ER/Outpatient 3 DOA Other Nursing Home 5 Residence 6 Other After this 1 Yes 28d. Describe how injury occurred 28a. Date of Injury 28b. Time of Injury 28c. Injury at Work? 27. Manner of Death Certification: Mar 16, 2012 Subject shot 1 Natural 1 Yes 2 ✓ No within 24 hours after death.

To the Funeral Director:
completely filled in by the f 5 Pending 2 Accident 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City 3 Suicide Could not be or Town, State) 2300 block of East Chase Street, Baltimore, MD (Specify) Local Street 4 V Homicide 29a. Certifier 1 Certifying Physicisn: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number O.C.M.E. March 17, 2012 arol llau 30. Name and address of person who completed cause of death (Item 23a) Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223 Carol Allan, MD 2. Registrar's Signature State Registrar

DHMH 17 Rev 1/2001 OCME 2006

OCME

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Physician/ Month Year Rose Marie Pierorazio 5:30am Medical 2012 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Stella Maris Hospice Towson Baltimore Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 208-16-1979 May 22, 1925 1 🗆 M 2 🔀 F PA Director 86 or 28a-f show notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director MD Baltimore Essex 1 Yes 2 XNo 10e. Street and Number 10f. Zip Code 0 10g. Citizen of What Country? an "natural", or items 23a or Medical Examiner must be Funeral 610 HIghvilla Road 21221 USA 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces? Black. White, etc þ 1 Never Married 2 Married Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 No Specify: Specify: White Completed 3 X Widowed 4 Divorced Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) other than Elementary/Secondary (0-12) College (1-4 or 5+) the Homemaker 5th own home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental + Department of Health and Menta Important: If item 27 is marked any injury or other them. ဂ္ James Vincent Lipari MAria Petrancosta 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Genoeffo Pierorazio /son 610 Highvilla Road Balto. MD 21221 Baltimore, 20a, Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 XBurial 2 Cremation 3 Removal from State cemetery, crematory or other place, SacredHeartofJesus 3/27/12 Baltimore MD 4 Donation 5 Other (Specify) Signature of ral Service License ame and Address of Facility 300 MAce Ave. Balto. M D Connelly Funeral Home of Essex 21221 22. Name and Address of Facility come dications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ne cause on each line. 23a. Part 1. Enter the disease, or composhock, or heart failure. List only or Approximate Interval Between Onset and Death Immediate Cause (Final Physician. STAGE disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions Examine cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a considence of A RES use as the burial-transi attending physician and Due to (or as a consequence of) 21, Physician/Medical Box 68760 MARCH IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No 5 Other (specify) Month Dav Year signed by the at id be detached for P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 Division of Vital Records, 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed should 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a Was an PIERORAZIO page 2 s has autopsy performe Hospital or Attending Physician: The 24 hours after death. Funeral Director: After this certificate by filled in by the funeral director, 25. Was case referred to medical To Be 26. Place of Death (Check only one) examiner? Other: 2 No 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) Manner of Death 28c. Injury at work?
1 ☐ Yes 2 ☐ No Certificate: 28b. Time of 28d. Describe how injury occurred 1 Natural
2 Accident injury 5 Pending ROSE Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 X Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check To the within 2 only one) 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) 29c. License numbe reis CRNF 03-21-2012 043580 slin 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) CRNP 2300 DULANEY VALLEY ROAD TIMONIUM, MD 21093 JUSTINE PREIS,

State Registrar 32. Registrar Signat

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Sharon Ann Pearl	State of M 1- For State Registrar	aryland / Department o <i>Certificate o</i>		ygiene Reg. No. 20	112 0895
Physician/ Medical Examiner	Decedent's Name (First, Middle,Last)	r1		2. Date of Death Month Day Year March 18, 2012	3. Time of Death 1935 hrs
	4a. Facility Name (if not institution, give street 106 South Hollins Ferry Rd		4b. City, Town, or Location of Oeath Ferndale		
Funeral Director	5. Social Security Number 6. Sex 220–78–9108	7. Age (In yrs. last birthday) The first state of the st	If Under 1 Year If Under 24Hrs Months Days Hours Min	8. Date of Birth (MM/DD/YYYY)	
laryland 8a-fahow any at once.	Usual Residence of Decedent 10a. State 10b. County MD Anne Arunde	10c. City, Town or Local L Co. Glen Bu	rnie		10d. Inside City Limits 1 Yes 2 XXNo
the Maryland a or 28a-f sh rified at 9050 Director	10e. Street and Number 106 South Hollins	Ferry Road	10f. Zip Code 21061	10g. Citizen of What United	
hours after death with the Maryland "natural", or items 23a or 28a-f she Examiner must be notified at noce sed by Funeral Director		med Forces? If Y Yes 2 X No Sive Year 1	Is Decedent of Hispanic Origin? (Si es, specify Cuban, Mexican, Puerto Yes 2 X No specify:	pecify Yes or No- Rican, etc.) 14. Race - White, Specify: W	
2 3 7	15. Decedent's Education (Specify only higher Elementary/Secondary (0-12) 12	est grade completed) 16a. Deceder during m	nt's Usual Occupation (Give kind of vost of working life. DO NOT use retinated in the contraction of the con	BWI/ Northro	ness/Industry p Grumman
be fi	17. Father's Name (First, Middle, Last) Bobby Lee Overly		Chris		
	19a. Informant's Name/Relationship (Type, Pri Mrs. Christine A. Ma	lock/mother 237	4 Willowview Driv		27253
2 2 2 2 3	20a. Method of Disposition 1 Burial 2 Cremation 3 Rem 4 Donation 5 Other Specify:	oval from State crematory or ot Atlantic	Crematory 03/	23/2012 Glen Bu	ity or Town, State
Baltimo permit. Page Department of Important: injury or oth	21. Signature of Euneral Service Licensee	M01121 Se:	rvices PA: 1 2nd	ngleton Funeral Ave SW; Glen Bu	rnie,MD 21061
Physician /Medical Examiner		that caused the death. Do not enter the Atherosclerotic Consuming or as a consequence of:	ne mode of dying, such as cardiac of ardiovascular Di	r respiratory arrest, shock, or heart sease complicate	Approximate Interval Between Onset end Death
ted Insit Examiner	Sequentially list conditions, if any leading to immediate cause. Enter theying Cause (Disease or injury that initiated	or as a consequence of):			
xecui n and I - tra	d. X UNPENDED X AME	DED 23a,pt.II,27,2 Der fh,g926 4-3	8a-f,per me,g925	3-23-12 sm	
Division of Vital Records, P.O. Box 68760, To the Hospital or Atteodiog Physician: The law requires that the death certificate be envithin 24 hours after death. To the Flueral Director: After this certificate has been signed by the attending physicial completely filled in by the funeral director, page 2 should be detached for use as the burshedical Certification: To Be Completed by Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	f yes, outcome of pregnancy Live birth 2 Fe Pregnant at time of death 5 Ot	tal death 3 Ectopic pregna	23d. Date of de	olivery Day Year
P.O. Bost that the degree of detached for by the by Phy.	Part II. Other significant conditions contrib	Unknown uting to death but not resulting in the u	inderlying cause given in Part I.	23e. Did tobacco use contribu	_
Division of Vital Records, P.O. ral or Atteodieg Physician: The law requires that it is after death. In Director: After this certificate has been signed by led in by the funeral director, page 2 should be detactor. To Be Completed by F	alcohol Use			24a. Was an 24b. We autopsy performed? dea	Probably 4 Unknown re autopsy findings available or to completion of cause of tth?
ital Recition: The lictor, page	25. Was case referred to medical examiner? Hospital:		26.Place of Death (Check	only one)	Yes 2 No
of Vision Physical Physical After this funeral dir.	1 Yes 2 No 27. Manner of Death 1 Notice 28a	Inpatient 2 ER/Outpatient Date of Injury (Month, Day, Yaar) 28b. Time of I	njury 28c. Injury at Work?	g Home 5 Residence 6 20	
Division o To the Hospital or Atteodiog within 24 hours after death. To the Fluoeral Director: Aft completely filled in by the fune	2 X Accident Investigation 1 Suicide 6 Could not be determined (s.	d 3-18-12 fd 19:3 b. Place of Injury - At home, farm, street pecify) Page idence	at, factory, office building, etc.	Drowned in batht 28f. Location (Street and Number of Town, State) 106 S	or Rural Route Number, City
To the Hospit within 24 hour To the Fucer. Completely fill ledical Cedical Ced	29a. Certifier 1 Certifying Physician: To to (Check only one) 2 Medical Examiner: On the	Residence he best of my knowledge, death occur basis of examination and/or investigat nner stated.	red at the time, date and place, and		stated.
	29b. Signature and title of certifier Curr of Hull	lau	29c. License number O.C.M.E.	29d. Date signed March 19, 20	(Month, Day, Year) 112
10 okpen		dical Examiner 900 W. Balt		D 21223	
State Registrar	31. Date filed (Month, Day, Year)	32 Registrar's Signatura	W		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 12:35 P M 2012 March 14 Jean A. Plowman Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** St. Elizabeth Nursing Center **Baltimore** 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth Funeral 217-18-0522 Hours (Month, Day, Year) Director 88 Yrs. March 17,1923 Maryland ms 23a or 28a-f show must be notified at 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. Count Director Baltimore Halethorpe 1 Yes 2 No Maryland | 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Funeral 1821 Palo Circle 21227 United States ed other than "natural", or items event, the Medical Examiner mu 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 X Married by Yes Yes, Give 2 XNo Maryland 21215-0036 1 Yes 2 X No Specify: Specify: White 3 Widowed 4 Divorced Completed Year or Dates Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) d 2 should be filed within 7 alth and Mental Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) N/A Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ٥ Lawrence C. McDaniel Adelaide Johanna Weissner other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health and 2 sin moortant: If item 27 is any injury or other transponds 1821 Palo Circle, Halethorpe, Maryland 21227 Paul B. Plowman / Husband Baltimore, 20a. Method of Disposition 20c. Location - City or Town, State 20b. Place of Disposition (Name of Date 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State cemetery, crematory or other place) Mar. 17,2012Woodlawn, Maryland Lorraine Park Cem. Donation 5 Other (Specify) 22. Name and Address of AMBRSOE FUNERAL HOME, INC. Funeral Service Licens 1328 Sulphur Spring Rd., Arbutus, Maryland 21227 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Onset and Death Immediate Cause (Final Ph_sician/ heimer disease or condition resulting in death) Medical Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) ty 110th and-tran that initiated events resulting in death) Last attending physician at for use as the burial Physician/Medical that the death certificate be Box 68760 IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery ☐ Live Birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy ☐ Pregnant at time of death 5 ☐ Other (specify) ____ in the past 12 months? Month Day Year 1 Yes 2 No 9 Unknown Division of Vital Records, P.O. been signed by should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy performed' certificate 1 ☐ Yes 2 📝 No or Attending Physician: 25. Was case referred to medica examiner? 26. Place of Death (Check only one) Hospital 2 X No 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 X Nursing Home 5 Residence 6 Other (Specify) this After this funeral of 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural Accident iniury work?
1 Yes 2 No 5 Pending n 24 hours aner ware to Funeral Director: Af Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Hospital Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier within 24 ho

To the Fune

completely f Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 20 enule enson 31. Date filed (Month, Com Year) State Registrar

ORIGINAL

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Mary Elizabeth Parlier 8:09 P March 2012 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 5524 Patrick Henry Drive Baltimore Anne Arundel 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Funeral Months Hours (Month, Day, Year) 212-34-0777 1 🗆 M 2 👿 F **Director** Maryland 1936 75 Yrs. Sept. 25, Usual Residence of Decede 28a-f show 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State notified at Director N/A Maryland Baltimore City 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? er than "natural", or items 23a or the Medical Examiner must be Funeral 2676 Eagle St. 21223 United States within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-12. Was Decedent Ever in U.S. 14. Race - American Indian. 11. Marital Status Armed Force If Yes, specify Cuban, Mexican, Puerto Rican, etc. Black, White, etc. 1 Never Married 2 Married þ 2 💢 No Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 ☑ No Specify: 3 X Widowed 4 □ Divorced Specify: White Completed Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Page 1 and 2 should be filed within 7 Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic. College (1/4 or 5+) Elementary/Secondary (0-12) Supervisor Book Binding Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည John Earl Cochran Elsie Lowman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Kimberly P. Gray/ Daughter 5524 Patrick Henry Dr., Baltimore, Maryland 21225 20a. Method of Disposition 20c. Location - City or Town, State 20b. Place of Disposition (Name of Date 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) cemetery, crematory or other place, Mar.19,2012 Glen Burnie, Maryland Atlantic Crematory 21. Signature of Foneral Service Licenses 22. Name and Address of Facility AMBROSE FUNERAL HOME, INC. Sulphur Spring RD., Arbutus, Maryland 21227 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a c sequence of **Examiner** Sequentially list conditions, if any, leading to immediate cause. Linter Underlying Examine Due to (or as a consequence of) Cause (Disease or injury that initiated events Due to (or as a consequence of) resulting in death) Last attending physician Physician/Medical certificate be Division of Vital Records, P.O. Box 68760 the for use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Pregnant at time of death 5 Other (specify) signed by the at Id be detached for Yes No 9 Unkno Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 Yes 2 No 3 Probably 4 Unknown Completed should 24b. Were autopsy findings available 24a. Was an autopsy performed? Yes 2 No page 2 prior to completion of cause of death?

1 Yes 2 No certificate funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Daughter House Other: 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA ဂ္ 4 Nursing Home 5 Residence 6 XOther (Specify after death.

Director: After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28b. Time of Natural 28d. Describe how injury occurred injury 5 Pending Accident Investigation Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 🗌 Homicide determined

Hospital or Attending Physician: Medical Certificate: filled in by the within 24 hours a

To the Funeral D Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier completely Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29c. License number 29b. Signature and title of certifier 20/2 30. Name and address of person who completed cause of death (Item 23a) (Type, Prin State 2 Registrar DHMH 17 Rev 06-2011 ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death MARCH 17 ROBINSON WESLEY **HENRY** 2012 7:08 AM 4b. City, Town, or Location of **TOWSON** 4a. Facility Name (if not institution, give street and number inty of Death **BALTIMORE** GILCHRIST HOSPICE CENTER 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) . Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | if Under 24 Hrs. Hours 216--52-9530 1**X** M 2 \square F 62 6-28-1949 MARYLAND Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits MD BALTIMORE **ESSEX** 1 🗌 Yes 2 💢 No 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 7141 GOLDEN RING ROAD 21221 U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11 Marital Status Armed Forces Black, White, etc. 1 Never Married 2XXMarried X Yes 2 No Yes, Give 1 Yes 2X No Specify: WHITE Specify: 3 Widowed 4 Divorced Year or Dates. 1969 – 71 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business/Industry (Give kind of work done during most of working life, DO NOT use retired) (Specify only highest grade completed) College (1-4 or 5+) Elementary/Secondary (0-12) STATE OF MARYLAND MECHANIC 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) HENRY ROBINSON IDA F. BERNARD W. 19b, Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 7141 GOLDEN RING RD ESSEX, MD NANCY L. ROBINSON/WIFE 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date 1 😾 Burial 2 □ Cremation 3 □ Removal from State 3-21-2012 BALTIMORE, MD GARDENS OF FAITH 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility CVACH / ROSEDALE FUNERAL HOME 21. Signature of Funds Scruce I censee ROSEDALE, 1211 CHESACO AVE

Ptoysician Medica **Examine**

Physician/

Medical

10a. State

Director

Funeral

by

Completed

Be

ဂ္

Examiner

Funeral

Director

28a-f show

27 is marked other than "natural", or items 23a or 28a-f sho traumatic event, the Medical Examiner must be notified at

and Mental Hygiene.

it. Page 1 and 2 should be rtment of Health and Mer rtant: If item 27 is mark, njury or other traumatic

permit. Page 1
Department of Important: If it any injury or o

within 72 hours after death

Baltimore, Maryland 21215-0036

within 24 hours after death To the Funeral Director: A

To the Hospital or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760

	shock, or heart failure. List only or lmmediate Cause (Final disease or condition resulting in death)	a	Astor	to colon C	Ancer		Interval Between Onset and Death		
Examiner	Sequentially list conditions, if any, leading to immediate cause. Litter ordenying Cause (Disease or injury that initiated events	b. Due to (or as a consequence of) Due to (or as a consequence of) C. Due to (or as a consequence of)	:						
	resulting in death) Last	d							
Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 4 Pregnant at time of death g Unknown	3 Ectopic 5 Other (23d. Date of de Month	elivery Day Year		
þ	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to								
Completed	24a. Was an autopsy erformed? performed? 1 \(\text{ Yes } 2 \(\text{ No } 1 \) Yes								
Be (25. Was case referred to medical			26. Place of Death (Che	ck only one)		11		
P B	examiner? 1 Yes 2 No	Hospital: 1 ☐ Inpatient 2 ☐ ER/Out	patient 3 🗆	DOA Other:	lome 5 - Residence	6 Other (Spec	city) Hospite		
Certificate: T	27. Manner of Death 1 Natural 5 Pending 2 Accident Investigation	28a. Date of injury (Month, Day, Year) 28b. Tir inj		28c. Injury at work? 1 ☐ Yes 2 ☐ No	28d. Describe how in				
al Certif	3 Suicide 6 Could not be determined	28e. Place of Injury - At home, farm building, etc. (Specify)	ory, office	28f. Location (Street City or Town, St		ıral Route Number,			
Medical	(Check 2 Medical Exami	sician: To the best of my knowledge, doner: On the basis of examination and/or se Practitioner: To the beat of my know	investigation, i	n my opinion, death occurred	at the time, date and pl	ace, and due to the	cause(s) and manner stated		
	29b. Signature and title of certifier	hmy Kileyo	2	9c. License number	204	Date signed (Mont			

DHMH 17 Rev 06-2011

Registrar

State

31. Date filed (Month, Day,

MAR 2 2 2012

N-Charlast, Balton md 2120x

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND ITEM#5perFH,G925,3/30/2012,WS
State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death Physician/ Month Lillian Charlene 12:30 PM Ridgell MARCH Medical 2012 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death County of Death Anne Arunde BURNIE Baltimore Washington Medical Center Glen 7. Age (In vrs. last hirthday) If Under 24 Hrs 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign **Funeral** -40-0486 **Director** 70 1 □ M 2 🗓 F Aug. 9, 1941 Maryland or 28a-f shoven 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No MD N/A Baltimore ō 10e. Street and Number 10f. Zip Code ms 23a or must be n 10g. Citizen of What Country? Funeral 2615 Northshire 21230 USA items 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give "natural", or item edical Examiner n 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. by 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify: White 3XX Widowed 4 ☐ Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) marked other than Elementary/Secondary (0-12) College (1-4 or 5+) the Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) မှ Walter Edward Patrick Smith Elsie Marie Wheeler 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code S Sandra Maize-Daughter 863 Elmwood Court, Westminster Maryland 21258 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 9 1X Burial 2 ☐ Cremation 3 ☐ Removal from State cemetery, crematory or other place Department of Important: If any injury or Meadowridge Mem Gard Mar. 26, 2012 Elkridge Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Am rose Funeral Home of Lansdowne Signature of Faneral Service Licensee 2719 Hammonds Ferry Road Lansdowne Maryland 21227 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line interval Between Immediate Cause (Final Onset and Death Ph_sician/ Wthmow. disease or condition resulting in death) Medical Due to (or as **Examiner** Sequentially list conditions, it any leading to immediate cause. Enter Underlying Examiner Due to (or as a nonsequence o Cause (Disease or injury use as the burial-tran and that initiated events resulting in death) Last Due to (or as a consequence of): attending physiciar Physician/Medical that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Pregnant at time of death 5 Other (specify) the Unknown þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an has autopsy performed Director: After this certificate Yes 2 Hospital or Attending Physician: filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 No 2 1 🗖 Inpatient 2 🗀 ER/Outpatient 3 DOA 4 \square Nursing Home 5 \square Residence 6 \square Other (Specify) 28c. Injury at work? 1 ☐ Yes 2 ☐ No 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28d. Describe how injury occurred injury 1 Natural 5 Pending Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined hours after within 24 hours To the Funeral Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a Certifier 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month. Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Ye

DHMH 17 Rev 06-2011

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			/ Department of Health and	Mental Hygie	ene
		State Registrar	Certificate of Death	Reg	g. No. 2012 08962
Physic	cian	1. Decedent's Name (First, Middle, Last) Wayne Darcy Simmons, Sr.		2. Date of Death	Day Year 3. Time of Death
Me	dica				16 2012 8:40 P M
Exam	nineı		4b. City, Town, or Location of Dea	ith	4c. County of Death
Funer	rol le	Rock Glen Nursing And Rehabilita 5. Social Security Number 6. Sex 7. Age (In yrs. last	ation Baltimore City birthday) If Under 1 Year If Under 24 Hr	s. 8. Date of Birth	O Birthulass (O)
Direct			Months Days Hours Mir		(ear) 9. Birthplace (State or Foreign Country) Maryland
_ MC		Usual Residence of Decedent		NOV. 20,	, 1931 Maryland
yland •f sho	1	10a. State 10b. County 10c. City, T Halet	own or Location		10d. Inside City Limits
e Mau r 28a notifi	Director	10e. Street and Number	thorpe		1 Yes 2 No
ith th	1 2	Toe. Street and Number	10f. Zip Code	10	g. Citizen of What Country?
ath w	Firegraf	5 901 Stormont Circle 11. Marital Status 12. Was Decedent Ever in U.S.	21227 13. Was Decedent of Hispanic Origin? (nited States
or it	3	Armed Forces? 1 Never Married 2 Married 1 Yes 2 No	If Yes, specify Cuban, Mexican, Pue		14. Race - American Indian, Black, White, etc.
Ural",	3	3 Widowed 4 Divorced If Yes, Give Year or Dates.	1 ☐ Yes 2 🟋No Specify:		Specify: White
Z13-UU36 in 72 hours after e. nan "natural", o Medical Exam	Completed	15. Decedent's Education (Specify only highest grade completed)	6a. Decedent's Usual Occupation (Give kind of work done during most of wo	orkina 16	6b. Kind of Business/Industry
TZT Tkhin 7 sne. than	٦	Elementary/Secondary (0-12) College (1-4-9-5+)	life. DO NOT use retired) Truck Driver		Transportation
ed wi Hygie other	Be			ama (Eisat Middle Ma	idea Communa)
Viana Id be filed Mental Hy arked ott	Ę		June Cu	ame (First, Middle, Mai rtain	den Sumame)
ary nould nd M		19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or R	ural Route Number Ci	ity ar Tawn State 7 in Cadal
d 2 should alth and alth and alth and artist is not artist is not artist is not artist is not artist in a second artist artist a second artist a second artist artist artist artist arti		1	901 Stormont Circle,H		
of He		20a. Method of Disposition 20b. Place	e of Disposition (Name of		Oc. Location - City or Town, State
Page Page ment ant: It		The state of the s	etery, crematory or other place) ntic Crematory Mar	. 20, 2012 G	Glen Burnie,Maryland
DEMILITIOFE, INIGITISING Z1Z13-UU30 permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at	ouce.	21. Sign. tre of Lungral Service Licensee	22. Name and Address of Facility A		
	ō	7 Time arter			outus, Maryland 21227
		23a. Part 1. Enter the disease, or complications that caused the death. D shock, or heart failure. List only one cause on each line.	o not enter the mode of dying, such as cardia	c or respiratory arrest,	Approximate Interval Between
Physici Medic		Immediate Cause (Final disease or condition repulting in death)			Onset and Death
Examine		resulting in death) Due to (or as a consequence)	· ·	l	
	ē 📕	Sequentially list conditions, if any, leading to immediate b. Due to (or a la consequence)	choree disease	adman	ce
rted J ansit	Examiner	if any, leading to immediate Due to (or a la consequent cause. Enter Underlying Cause (Disease or injury	33 31/1		
be executed sician and burial-transit	Ä	that initiated events c. Due to (or as a consequence)	ce of):		
ate be	dical	d			
tificar ring ph					
eath certificate attending p	Physician/M	23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregnancy 1 ☐ Live Birth 2 ☐ Fetal de	eath 3 Ectopic pregnancy		23d. Date of delivery
e dea the a	Vsic	1 Yes 2 No 4 Pregnant at time of deat 9 Unknown	h 5 Other (specify)		Month Day Year
requires that the despension of the should be detached			ng in the underlying cause given in Part I.	23e. Did tohac	cco use contribute to the cause of death?
o, lines til	yd by				2 ☑No 3 ☐ Probably 4 ☐ Unknown
v requires t been signatured should t	lete			24a. Was an	24b. Were autopsy findings available
he law te has age 2	Completed			autopsy performe	prior to completion of cause of d? death?
ysician; The la ysician; The la is certificate ha director, page	رة ا	25. Was case referred to medical	26. Place of Death (Che	1 Yes 2	No. 1 Yes 2 No
nysici nis cer	10 B		Other:		e 6 Other (Specify)
ding Ph h. After th funeral			p. Time of 28c. Injury at work?	28d. Describe how i	
tendi leath. tor: A the fi	ific	2 Accident Investigation 3 Suicide 6 Could not be	M 1 Tes 2 No		
or At after of Direct in by	Certificate:	4 Homicide determined 28e. Place of Injury - At home, building, etc. (Specify)	farm, street, factory, office	28f. Location (Stree City or Town, S	t and Number or Rural Route Number, tate)
spital ours a			a death occurred at the time date and place		
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-trans	Medical	(Check only one) 3 Certifying Nurse Practitioner: To the best of my kind only one) Certifying Nurse Practitioner: To the best of my kind only one)			
To th withir To th	2	29b. Signature and title of certifier	29c. License number	29d.	ause(s) and manner as stated. Date signed (Month, Day, Year)
		1 Smy Zum	D39127	3	/20/20/2
		30. Name and address of person who completed cause of death (Item 23a	a) (Type, Print)		λ
		DR-A-Ahmed 821 NE	Elev ST. Ball	word M	121201
St Regis	tate trar	31. Date filed (Month, Day, Year) NAR 2 2 2012 32. egistrar's Signature	here		
1.0910		TAR G ~ CUIL / BULL P.	1		

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First Middle Last) 2. Date of Death Physician/ JOSEPHINE **FERGUSON** THOMPSON Medical MARCH 4:00PM 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 3607 KENWAY STREET SILVER SPRING MONTGOMERY **Funeral** Social Security Number Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Yea 1ar 25 1 9. Birthplace (State or Foreign 1 - M 2 - F Hours Director 228-48-322 70 V<u>irginia</u> Mar. Usual Residence of Decedent 28a-f show 10a. State 10b. County Page 1 and 2 should be filed within 72 hours after death with the Maryland must be notified at 10c. City, Town or Location Completed by Funeral Director 10d. Inside City Limits 1 X Yes 2 No Md Montgomery Silver Spring 0 10f. Zip Code 10g. Citizen of What Country? 23a 3607 Kenway St. 20906 United States 11. Marital Status Was Deceud...
Armed Forces?
1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian "natural", or 1 Never Married 2 Married Black, White, etc. Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2x No Specify: 3 Widowed 4 Divorced Specify: Black ed other than "natur event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done life. DO NOT use retired) during most of working Elementary/Seconday (0-12) College (1-4 or 5+) Mental Hygiene. Executive Assistant Government Be 17. Father's Name (First, Middle, Last) f Health and Mental Hitem 27 is marked of other traumatic ever 18. Mother's Name (First, Middle, Maiden Surname) ပ Callie Hudson Ferguson Pearl May Austin 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Traci N. Thompson/Daughter 3562 other 65th Ave. Hyattsville, Md. item 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, Department of H Important: If ite any injury or otl 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Chesapeake Crem. 3 - 13 - 12Beltsville, Md. 21. Signa True f Funeral Service Lice 22. Name and Address of Facility Capitol Mortuary, <u>Maryland</u> <u>Ave.</u> 23a. Part 1. Enter the disease shock, or heart failure. It , or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ist only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph sician/ ADENOCARCINOMA disease or condition OF LUNG BRAIN METASTASIS yrs Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of) Examir burial-transit and Due to (or as a consequence of) attending physician Physician/Medical To the Hospital or Attending Physician; The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 the use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Pregnant at time of death Month Dav Year the 9 Unknown 9 Unknown signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🙀 Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2√☐ No page 2 s 24a. Was an autopsy performed? Yes 2 XN certificate 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital 2**X** No Other: this 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury Certificate: 28b. Time of ieral Director; After filled in by the funer 28c. Injury at work? 28d. Describe how injury occurred Natural
Accident
Suicide (Month, Day, Year) 5 Pending Investigation M 1 Yes 2 No 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical

within 24 hours a

To the Funeral C

completed filled

Registrar

29a, Certifier (Check

29b. Signature and title of certifie

Η

Gerard

Robert

MD

D0055522

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29d. Date signed (Month, Day, Year)

3 - 12 - 12

Silver Spring, Md.

DOD: March 21, 2012; Baltimore, Maryland 21215-0036 Robert Truchon Division of Vital Records, P.O. Box 68760

			Please '	Type or Pi	int in I			nk. Ensure f. perFH Health and	All Copie G925 Mental Hy	s Are 29/2(ygiene	Legible 12,WS	e.	00061
Dhysician		State Registrar 1. Decedent's Name (First,	Middle, Last	·)		Cer	tificate o	f Death	2. Date of D	Reg. No eath		,	3. Time of Death
Physiciar Medica Examine	al er	Robert 4a. Facility Name (if not ins 1412 Phoen:	titution, give s	d		Truc	4b. City, Towr Phoe Spat	:ks	March	4c.	County of De Balt:	12 eath imo:	
Funeral Director		5. Social Security Number 214-92-184 Usual Residence of Dece 10a, State 10b. 0		X M 2 □ F	49	Yrs. y, Town or Loc	If Under 1 Ye Months Da			ay, Year)	(eor	ace (State or Foreign y) gia d. Inside City Limits
the Marylan or 28a-f sh oe notified a	irecto		altimo	re	100.00	Phoenix Sparks 10f. Zip Code				10g. Cit	izen of What		1 ☐ Yes 2 🔣 No
permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at once.	ρ	1412 Phoen: 11. Marital Status 1 □ Never Married 2 3 □ Widowed 4 □ D	Married	12. Was Deceden Armed Forces 1 X Yes 2 If Yes, Give	?	1	Was Decedent of Yes, specify C	f Hispanic Origin? (Suban, Mexican, Puer	pecify Yes or No to Rican, etc.))-	USA 14. Race - Al Black, W		c.
vithin 72 hours liene. er than "nature the Medical E	Completed	15. [Decedent's Ed ly highest grad	Year or Dates. lucation de completed) College (1-4 o	r 5+)	(Give I	O NOT use retir	ne during most of wo		1	ind of Busine mmerci Esta	ss/Indi	ustry
d be filed v Mental Hyg arked othe	To Be	17. Father's Name (First, N	liddle, Last)		Truc				me (First, Middle	e, Maiden	Surname) Clay	ton	
and 2 should Health and N em 27 is me ther trauma		19a. Informant's Name/Re Margaret E 20a. Method of Disposition	Truc		205 5	1412_	ng Address (Street) Phoenix sition (Name of	ret and Number or R W•Pt Road, St	nenix	ary1a	2	113	<u>2</u>
mit. Page 1 a continuit. Page 1 a continuit of 1 contant: If it in injury or of 1 continuit.		1 Burial 2 💢 Cre 4 Donation 5 🗆	mation 3 🗆	Removal from Sta	te c	emetery, cren Lantic	Cremat	i	2/2012	G1e	n Burn	ie,	Maryland
Physician/ Medical		23a. Part 1. Ent the disease or condition resulting in death)	ease, or comp e. List only or	on anima an anah l		h. Do not ente	er the mode of	idonia Roa	d. Timo c or respiratory	nium,	MD 2	109	Approximate Interval Between Onset and Death
ath certificate be executed at attending physician and for use as the burial-transit	lical Examiner	Sequentially list condition if any, leading to immedia cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	is, te	b. Due to (or a	s a conseq	uence of:	Arky	Diseue					2 yeas
Attending Physician: The law requires that the death certificate be exact death. Fordor: After this certificate has been signed by the attending physician by the funeral director, page 2 should be detached for use as the burrie.	Physician/Medical	IF FEMALE: 23b. Was decedent pregn: in the past 12 month: 1 □ Yes 2 □ No 9 □ Unknown	ant	23c. If yes, outcon 1 ☐ Live Birt 4 ☐ Pregnan 9 ☐ Unknow	n 2 🗌 Feta t at time of	al death 3	Ectopic pregi				23d. Date of Month		y Day Year
requires that the desired signed by the should be detached	by	Part II. Other significant of the Company of the Co		Sleep			underlying caus	e given in Part J.		Yes 2	No 3 [Proba	e cause of death? ably 4 Unknown sy findings available
an; The law tificate has b tor, page 2 s	Be Completed	25. Was case referred to n	nedical				20	6. Place of Death (Ch	aut per 1 🗆 Yes	topsy rformed?	prior	to com	pletion of cause of
To the Hospital or Attending Physician; The la within 24 hours after death. To the Funeral Director: After this certificate ha completely filled in by the funeral director, page:	မ	examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Accident	Pending Investigation	28a. Date of i	-	ER/Outpatie 28b. Time of injury	f 28c. I	Other: 4 Nursing njury at vork? Yes 2 No	Home 5 Re			oecify)	
ital or Atte urs after de: al Directoi lled in by th	al Certificate:	4 Homicide	Could not be determined	building,	etc. (Specif	y)	reet, factory, off		City or To	own, State	·)		Route Number,
To the Hospital or within 24 hours afte To the Funeral Dire completely filled in	Medical	(Check 2 Monly one) 3 Co	edical Exami ertifying Nurs certifier	ner: On the basis of se Practitioner: To	f examination the best of	on and/or inves my knowledge	stigation, in my o e, death occurred 29c. Lic	at the time, date and	d at the time, date place, and due to	e and place o the cause 29d. Da	e, and due to t e(s) and mann ate signed (Mo	he causer as st	se(s) and manner stated ated. ay, Year)
1		30. Name and address of PETER A R	person who d	completed cause c	f death (Iter	n 23a) (Type, I	Print)	. Suite	360 W	ESTM	MSTER	۸ ح	10 21157
Stat Registra		31. Date filed (Mooth, Day	Year) 2 2012	Senter.	strar's Sig	ature	الما						

Registrar DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Month Year 00 55 PM **Physician** H THORNHILL 17 March 2012 JAMES. /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Johns Hopkins Bayview Medical Center **Baltimore** If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. 8. Date of Birth Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** X1 X M 2 □ F Director 226-30-5508 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b County r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 1 XYes 2 □ No Director Turner Station MD 10g. Citizen of What Country? 10f Zin-Code 10e. Street and Number Pages 1 and 2 should be filed within 72 hours after death with inent of Health and Mental Hygiene.
Int; If item 27 Is marked other than "natural", or items 23a or 149 Chestnut Street Funeral 21222 14. Race - American Indian, Was Decedent Ever in U.S. Armed Forces 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☐
If Yes, Give
Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify Specify. þ Black 3 Widowed 4 □ Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Bethlehem Steel Mechanic 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be and Mental John Thomhill Matilda ည 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) of Health of tem 27 I 149 Chestrut St. Baltimore, MD Delvis Johnson/Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a Method of Disposition Department of IImportant: If ite
any injury or ot
once. 1 Burial XXX Cremation 3 Removal from State 4 Donation 5 Other (Specify) 3-20-2012 Baltimore, MD Metro Crematory and Address of Facility James A. Morton & Sons F. H., Inc. 21. Signature of Funeral Service Licensee a. 1701-31 Laurens St. Baltimore, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician ALKOPPH disease or condition /Medical resulting in death) Due to (or as a consequence of) Examiner Non-small cell lung COACE Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury Examiner Due to for as a conse quence of: The law requires that the death certificate be executed physician and as the burial-trans that initiated events resulting in death) Last Due to (or as a consequence of) Box 68760, Physician/Medical as IF FEMALE: use 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Live birth 2 Fetal death Month Day in the past 12 months? for Pregnant at time of death 5 Other (specify) detached 2 No Division of Vital Records, P.O. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably Pulmonary 1 Tes Completed 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death? has 2 No 2 No 1 Tyes Hospital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital: 1 ☑Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 🗌 Yes 2 ER/Outpatient 3 DOA ၉ 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 28b. Time of Certification: 5 Pending investigation After 1 Natural Injury 1 Yes 2 No eral Director; Af 2 Accident 3 Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide e Funeral C 1 Vertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (check only Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

State Registrar

11595

within 2 To the F

29b. Signature and title of certifier

31. Date filed (Month Day,

and manner stated.

M.D.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Wolle

ORIGINAL

29c. License number

RES-000

29d. Date signed (Month, Day, Year)

MARCH 17, 2012

4940 Eastern Avenue, Baltimore, MD, 21224

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2012 State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ March 20,2012 3:35am Venable Ruth Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Baltimore Towson Manor Care Dulaney Social Security Number 7. Age (In yrs. last birthday) 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🕱 F Months Days Hours Min. (Month, Day, Year) Country) 84 Director MD 220-18-5724 Usual Residence of Decedent 28a-f show 10b. County 10c. City, Town or Location 10a. State ral", or items 23a or 28a-f sho Examiner must be notified at 10d. Inside City Limits Director 1X Yes 2 □ No Baltimore MD n/a 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Funeral 21218 USA 1020 E. 33rd St. death \ 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 14. Race - American Indian, Black, White, etc þ 1 Never Married 2 Married 1 ☐ Yes 2x No If Yes, Give 72 hours after Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: Specify: Black "natural" 3 X Widowed 4 Divorced Completed Year or Dates the Medical Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) should be filed within 72 h and Mental Hygiene. 7 is marked other than "r Elementary/Seconday (0-12) College (1-4 or 5+) Balto. City School Professional 12th other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Mary Bartee-Cator Plummer Gilliam 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau 3517 Royston Ave. Baltimore, Md 21206 William Venable Jr/Son Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 DeBurial 2 Cremation 3 Removal from State GarrisonForestVet.CemMarch29,2012OwingsMills Md 4 Donation 5 Other (Specify). 21. Signature of Fundamental Incomeses 22. Name and Address of Facility BPRESTON ST. BALTO. HOME 21213 Ø 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physicianz disease or condition resulting in death) 1-0v Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of) and -trans that initiated events resulting in death) Last Due to (or as a consequence of): attending physician for use as the buria Physician/Medical certificate be 68760 IF FEMALE: 23d. Date of delivery 23b. Was decedent pregnant Box Live Birth 2 🗀 Fetal death 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Hospital or Attending Physician: The law requires that the death Day Month Year Pregnant at time of death ed by the a Unknown 9 Unknown P.O. signed by to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ CHF, COPP 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Division of Vital Records, Completed page 2 should peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has performed? within 24 hours after death. To the Funeral Director: After this certificate h 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? filled in by the funeral director, Be 26. Place of Death Check only one) Hospital Other: 2 No 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred injury work? 1 ☐ Yes 2 ☐ No 1 Natural 5 Pendina Accident Investigation 2 Accident
3 Suicide
4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month. Day, Year) 037573 5105 , 15 HarpM 30. Name and address of person who d cause of death (Item 23a) (Type, Print) 5872 South Ave MD MA Jef 31. Date filed (Month, Day Year) State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Physician/ March 17, Day 2012 Gentry Winn 9:50 AM Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City. Town, or Location of Death 4c. County of Death Maryland Masonic Homes Cockeysville **Baltimore** Social Security Number . Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8 Date of Birth **Funeral** 9. Birthplace (State or Foreign Year 1921 1 □ M 2 🛣 F Hours Min Director 307-16-0051 90 Country) I**ndiana** Usual Residence of Decedent 28a-f show ed other than "natural", or items 23a or 28a-f sho event, the Medical Examiner must be notified at 10a. State 10b. County be filed within 72 hours after death with the Maryland Director 10c. City Town or Location 10d. Inside City Limits 1 ☐ Yes 2 🛛 No MD Baltimore Hunt Valley 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 960 Western Run Road USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces? Black, White, etc. ģ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 🔀 No Specify: Specify: White Completed 3 X Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working and Mental Hygiene. life. DO NOT use retired) College (1-4 or 5+) Elementary/Seconday (0-12) Real Estate Broker 4+ Real Estate Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be Department of Health and Menta Important: If item 27 is marked any injury or other traumatic evone. ည James Gentry Carrie Coyle 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Scott Winn/Son 960 Western Run Road Hunt Valley, MD 21030 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State March 19, 1 Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) Atlantic Crematory 4 ☐ Donation 5 ☐ Other (Specify) 2012 Glen Burnie, MD 21. Signature of Functal Service Licensee 22. Name and Address of Facility emmon Funeral Home of Dulaney Valley. Inc. O W. Padonia Road Timonium, MD 21093 23a. Rad 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician melile disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): attending physician and for use as the burial-transit or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months? Month Pregnant at time of death Unknown 9 Unknown signed by the Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed page 2 should peen . Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? Yes 2 No Suns **Director:** After this certificate I 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Mursing Home 5 - Residence 6 - Other (Specify, 1 🗌 Yes 2 No ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work? 1 🗌 Yes 2 🗌 No Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) within 24 hours a To the Funeral I Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier

State Registrar 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year)

			State of Maryland / Departme		-	•	
			1 _ State	nte of Death	, ,	001	2 00000
			1. Decedent's Name (First, Middle, Last)	to or boarr	Date of Death	J. No.	3. Time of Death
	Physicia		Margaret Williams		Month	Day Year 19 2012	9:30P ^M
	/Medic Examin			y, Town, or Location of Death		4c. County of Deatl	
- 1			Homewood Genesis	Baltimore			
	Funeral		1 M 2 M Months	er 1 Year If Under 24 Hrs. s Days Hours Min.	8. Date of Birth (Month, Day,	rear) Co	hplace (State or Foreign untry)
	Director		158-36-9674 75 75 Usual Residence of Decedent		02 10	1937 S.	.С.
	yland now		10a. State 10b. County 10c. City, Town or Location				10d. Inside City Limits
	a-f st	ctor	MD Baltimor	ce			1 □Yes 2 □ No X
	or 28	Director		Zip Code	109	g. Citizen of What Co	untry?
	s 23a	ıral	1669 Darley Avenue	21213		JSA	
	item:	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ No	edent of Hispanic Origin? (Spo pecify Cuban, Mexican, Puerto	ecity Yes or No- Rican, etc.)	14. Race - Ame Black, White	
5-003e	72 hours after death with the Maryland "natural", or items 23a or 28a-f show "dical Evan her mast be notified at	by f	3 Widowed 4 Divorced Year or Dates:	2 No Specify:		Specify:Bla	ck
5	n 72 hou "natura	Completed	15. Decedent's Education 16a. Decedent's Us (Specify only highest grade completed) (Give kind of w	sual Occupation	ina 16	6b. Kind of Business/	Industry
7	d within giene.	mple	Elementary/Secondary (0-12) College (1-4or 5+)	vork done during most of worki use retired)			
7 0	al Hygiene. other than 'vent, in the	CO	8th Nursir 17. Father's Name (First, Middle, Last)	ng Assistant		Nursing	Center
and	be be eve) Be	William Taylor Sr.	To. World S Ivalie	unknow		
5	d 2 should be th and Menta 7 is marked traumatic ev	10		ss (Street and Number or Run			Zip Code)
Z Za	7 is		Sabrina Williams (daughter) 5714	The Alameda	Apt.B	Balto, Mo	1. 21239
o o	of H		20a. Method of Disposition 1 ☐ Burial 2X Cremation 3 ☐ Removal from State 20b. Place of Disposition (N cemetery, crematory or	ame of Cother place) Mar	20 20 20 20 20 20 20 20 20 20 20 20 20 2	Dc. Location - City or	
Itimor	t. Pages tment of tant: If it			Crematory.		alto,Md.	
g	permit. Page Department of Important: If any Injury or once.		21. Signature of Funeral Service Licensee Call Vi	and Address of Facility B - Scrugg	s Funer	al Home	
			11412	E. Preston ode of dving, such as cardiac			21213 Approximate Interval Between
~	Physician		shock, or heart failure. List only one cause on each line.	0-14			Onset and Death
	/Medical		disease or condition resulting in death) a. Due to (or as a consequence of):	failur C			30 MIN
	Examiner		Sequentially list conditions by lung cance	1, stage	1111		3 months
	ed sit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events)	i , stage	7		7 11
	be executed ician and ourial-transit	xan	that initiated events resulting in death) Last	iscular or	COUNT	7	3 mouths
		ä	U d.				
200	certificate nding phys	ledi					
X Q Q	th cer tendir r use	an/N	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal death 3 □ Ectopic	pregnancy		23d. Date of del Month	ivery Day Year
-	ne death the atten hed for u	Physician/Medic	1 ☐ Yes 2 ☑ ✓ 4 ☐ Pregnant at time of death 5 ☐ Other (specify)		WOTHER	Day real
7.	that the ed by detac		Part II. Other significant conditions contributing to death but not resulting in the underlying	cause given in Part I.	23e. Did toba	acco use contribute to	the cause of death?
ecords,	w requires that the de been signed by the should be detached	d by	lung atelectasis		1 ☐ Yes	2 No 3 P	robably 4 Unknown
	law rec as bee 2 shou	olete	dusphagia		24a. Was an	24b. Were au	utopsy findings available completion of cause of
Ĭ	The la ate ha	Completed	duanthia		autopsy perform 1 🗆 Yes 2	ed% death?	completion of cause of
Vital	clan: ertifica ctor, p	Be C	25. Was case referred to medical examiner?		h (Check only one,		
0	hysion this on	2	1 ☐ Yes 2,☐No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ I			nce 6 Other (Spe	cify)
u C	ding F	ion:	27. Manner of Death PS Natural 5 ☐ Pending (Month, Day, Year) 2 ☐ Accident investigation M	28c. Injury at Work? 1 ☐ Yes 2 ☐ No	28d. Describe hov	v injury occurred	
DIVISION	Attenrideat	fica	3 Suicide 6 Could not be 28e, Place of Injury - At home, farm, street, factor			eet and Number or Ru	ural Route Number,
É	s after	Certification:	4 ☐ Homicide determined building, etc. (Specify)		City or Town,	State)	
	To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2 seconds.	Medical	29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, death occurre on the basis of examination and/or investigation and manner stated.	ed at the time, date and place, on, in my opinion, death occur	and due to the ca red at the time, da	use(s) and manner atte and place, and due	s stated. e to the cause(s)
	To th withir To th comp	Me	29b. Signature and the of certifier	29c. License number		d. Date signed (Mont	h, Day, Year)
			· Giggaraflernot	D00454		3/19/	12
n	V		30. Name and address of delegan who completed cause of death (Item 23a) (Type, Print) Ava Wava G. Pasakuwpo W!	Gever	sis Hov	newood_	Rolling
	Sta	te	31. Date filed (Month, Day Yeer) 32. Rejector's Signature 32.	0.	11951	DVA AVE	DOHIMONE
	Registr		MAD 2 2 2012 June S. Save				

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ STANLEY WOJTAS MARCH 2 Pay 2012 3:00 A M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** BALTIMORE 7922 31st STREET ROSEDALE ocial Security Numbe If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign **Funeral** Months Days Hours 216-20-4738 Director 5-21-1926 85 MARYLAND Yrs Usual Residence of Decedent 28a-f shov 10a. State 10c. City, Town or Location 10d. Inside City Limits Examiner must be notified at Director ROSEDALE MD BALTIMORE 1 Yes 2 Xo 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 23a Funeral 7922 31st STREET 21237 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 □ XYes 2 □ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 Never Married 2 X Married þ Baltimore, Maryland 21215-0036 72 hours after 1 ☐ Yes 2 😾 No Specify "natural", Specify: WHITE 3 Widowed 4 Divorced Completed Year or Dates. 1943-46 the Medical Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) CRANE OPERATOR BETH STEEL Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental 2 ANDREW WOJTAS MARY ANNE KRUZLA 19a. Informant's Name/Relationship (Type, Print)
LAURA R. WOJTAS/WIFE 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) .8 ROSEDALE, MD 21237 7922 31st STREET Important; If item any injury 20b. Place of Disposition (Name of cemetery, crematory or other place)
HOLLY HILL MEM. 20a, Method of Disposition Date 20c. Location - City or Town, State . Page 1 1 X Burial 2 Cremation 3 Removal from State 3-24-2012 4 ☐ Donation 5 ☐ Other (Specify) MIDDLE RIVER, MD 22. Name and Address of Facility CVACH / ROSEDALE FUNERAL HOME 21. Signature of Funeral Service Licensee 1211 CHESACO AVE ROSEDALE, MD 21237 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ CHRONIC RENAL disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of) Examin Cause (Disease or injury that initiated events Due to (or as a consequence of): resulting in death) Last physician Physician/Medical requires that the death certificate be Division of Vital Records, P.O. Box 68760 the attending pl IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No Day Month Year 4 Pregnant at time of death 9 Unknown 9 Unknown by 1 Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 DISEGIC 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy 1 Yes 2 No 1 ☐ Yes 2 ☐ No Hospital or Attending Physician; 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 \(\sum_{\text{Nursing Home}}\) 1 \(\frac{5}{\overline}\) Residence \(\frac{6}{\omega}\) Other (Specify, Hospital 1 ☐ Yes 2 📉 No မ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred injury work? 1 ☐ Yes 2 ☐ No 1 Natural 5 Pending Accident Investigation Funeral Director: Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined 24 hours 29a. Certifier 1 🗷 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 20 143 140480 0 2012 March 21 130610 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Tenno, ms 10V 21236 ERNANDO

State Registrar 32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ March Medical 4a. Facility Name (if not institution, give street and number, or Location of Death 4c. County of Death **Examiner** HIMOre Tohns If Under If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** (Month, Day, Yea 6/25/1947 Director MARYLAND 216-44-6533 1 🕅 M 2 🗆 F 64 28a-f show 10a. State 10b County Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or items 23a or 28a-f sho 10c. City. Town or Location 10d. Inside City Limits injury or other traumatic event, the Medical Examiner must be notified at Director ANNE ARUNDEL MARYLAND ANNAPOLIS 1 Yes 2 XNo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 25 WEST WASHINGTON STREET USA 21401 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No
If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. þ 1 Never Married 2 Married Maryland 21215-0036 Specify: BLACK 1 ☐ Yes 2 X No Specify Completed 3 Widowed 4 X Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 12 COOKING CHEF Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည GEORGE BUTLER DOROTHY FORRESTER 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) LISA ARMSTRONG/NIECE 916 EAST HAM COURT CROFTON, MARYLAND 21114 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1 a
Department of H
Important: If ite
any injury or ot Date 1X Burial 2 Cremation 3 Removal from State BESTGATE MEMORIAL 3/9/2012 ANNAPOLIS
22. Name and Address of Facility LASTING TRIBUTES FELLOWS,
HELFENBEIN & NEWNAM CREMATION & FUNERAL
814 BESTGATE ROAD ANNAPOLIS, MD 21401 4 Donation 5 Other (Specify) Signature of Funeral Service Lio CARE 1. Enter the disease, chock, or heart failure. List complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ HNOXIC disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Due to (or as a consequence of): shaala Hospital or Attending Physician: The law requires that the death certificate be executed resulting in death) Last cell carcinoma of tonsil Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Month Pregnant at time of death 2 No 9 Unknown 9 I Inknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Be Completed by Division of Vital Records, 1 X Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed certificate has 1 Yes 2 No 25. Was case referred to medica 26. Place of Death (Check only one) examiner? Hospital Other: 2 2 No 1 XInpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) Date of injury (Month, Day, Year) Manner of Death 28b. Time of No the nosperse within 24 hours after death.

To the Funeral Director: After fined in by the funer Certificate: 28c. Injury at work? 28d. Describe how injury occurred Natural 5 Pending 1 Yes 2 No Accident Investigation Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 🗆 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier MO PHD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) N. Wolfe St. Baltimore MD 21287 Nuzar 000 Susanna LOUP

DHMH 17 Rev 06-2011

Registrar

State

MAR O

Box 68760, P.0. Division or Vital Records,

To the Hospital or Attending Physwithin 24 hours after death.

To the Funeral Director; After this completely filled in by the funeral di

State

Registrar

Medical

29a, Certifier

(Check only one)

29b. Signature and title of certifier

Negi 31. Date filed (Month, Day,

M.D 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

8601 Veterans Hwy

Millersville, MX 21108

29c License number

29d. Date signed (Month, Day, Year) March 2, 2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Burrows, Jr. 02 Roy Folsom \mathbf{P}^{M} 2012 4:30 March Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 1649 Secretariat Drive <u> Annapolis</u> <u>Anne Arundel</u> Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** (Month, Day, Year) Months Davs Hours 219-40-4414 66 Director 1 🛛 M 2 🗆 F July 08,1945 New Hampshire Usual Residence of Decedent 28a-f show 10c. City, Town or Location 10d. Inside City Limits ral", or items 23a or 28a-f sho Examiner must be notified at 10a. State Director Annapolis MD Anne Arundel 1 Yes 2 X No 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 21409 1649 Secretariat Drive and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 2 No
If Yes, Give 1967 Black White, etc. "natural", or þ 1 Never Married 2 X Married Saltimore, Maryland 21215-0036 White 1 ☐ Yes 2X No Specify. 1969 Specify Completed 3 Widowed 4 Divorced Year or Dates Medical Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) d Mental Hygiene. marked other than Elementary/Secondary (0-12) College (1-4 or 5+) other traumatic event, the Construction Roofing Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ Inez Sewall Roy Folsom Burrows, Sr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health a 1649 Secretariat Drive Annapolis, MD 21409 Linda Burrows / Wife 20a Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State March 09 Department of H Important: If ite any injury or ot Page 1 1 ☐ Burial 2 ☆ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Baltimore, MD Metro Crematory, INC. 2012 21. Signature of Funeral Service Louisee 22. Name and Address of Facility Barranco & Sons, P.A. Severna Park Funeral Home Severna Park, MD 21146 495 Ritchie Hwy 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final canal Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of). Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): Cause (Disease or injury that initiated events attending physician and for use as the burial-trar Due to (or as a consequence of): resulting in death) Last Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ After this certificate has been signed by the atterneral director, page 2 should be detached for in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy Yes 2 No 2 No 1 Yes after death.

Director: After this certifice
J in by the funeral director, p 25. Was case referred to medical examiner?
1 ☐ Yes 2 No Be 26. Place of Death (Check only one) Hospital Ž/No ၉ 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred Natural injury 5 Pending 1 ☐ Yes 2 ☐ No Investigation Accident 6 Could not be 3 ☐ Suicide 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, completely filled in by determined City or Town, State) within 24 hours a

To the Funeral C Medical 1 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of cer 29c. License number 29d. Date signed (Month, Day, Year) D38158 20/2 5+/10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 06-2011

State Registrar 2007 Me. Registrar's Siànat

		AMEND PI LINE Please AMEND #26 PER	B, 25, PE Type or Prir VERBAL G9 State of Ma Amend 23a	R ME nt in B 29 77 aryland per m	lack Indel 5/12 TR 1/Departr ed Cert	16/12 ible Ink cate of	i. Ensu Feath r	ire All and Me	Copies ental Hy	Are l	Legible.) no n -
Physic /Medi Exami	cal	1. Decedent's Name (First, Middle, La 4a. Facility Name (If not institution, giv	re street and number)	B	robs	City, Town, o			2. Date of De Month	0 3 4c.	Year ZO/ County of Dea	71
Funeral Director	Г	5. Social Security Number 6. S	Sex 7. Agr 7. Agr 7. Agr	e (In yrs. la	Mo	Inder 1 Year nths Days	If Under Hours	24 Hrs. 8 Min.	B. Date of Bir (Month, Da March		9. Bir	thplace (State or Ford
a-f show	ctor	Usual Residence of Decedent 10a. State 10b. County MD Garrett		,	Town or Location	n						10d. Inside City Lin
with the	al Director	10e. Street and Number 633 Beall School	Rd.			of. Zip Code 21532				10g. Citi USA	zen of What C	ountry?
hours after death with the Maryland tural", or items 23a or 28a-f show at Examiner must be notified at	by Funeral	11. Marital Status 1 □ Never Married 2 🔯 Married 3 □ Widowed 4 □ Divorced	12. Was Decedent I Armed Forces? 1 Mayes 2 □ N If Yes, Give Year or Dates:	No	If Yes	Decedent of I , specify Cub es 2 X No	an, Mexicar	n, Puerto Ri	ify Yes or No ican, etc.)	-	14. Race - American Indian, Black, White, etc. Specify: White	
within 72 ene. than "na	Completed	15. Decedent's Er (Specify only highest grade) Elementary/Secondary (0-12)	ducation		16a. Decedent's (Give kind life. DO N	of work done OT use retire	pation during mos	t of working	9		nd of Business	•
be filectatal Hylectatal	To Be Co	17. Father's Name (First, Middle, Last, Cormany Brobst)				1	er's Name (First, Middle,	Maiden	Surname)	****
s 1 and 2 should f Health and Mei item 27 is marke other traumatic		19a. Informant's Name/Relationship (Anita J. Brobst/W	**		19b. Mailing Ac							and the second s
permit. Pages 1 and 2 Department of Health a Important: If item 27 is any Injury or other tra once.		20a. Method of Disposition 1 Burial 2 Termation 3 4 Donation 5 Other (Specif	Removal from State		ace of Disposition metery, cremator ntry Sic	(Name of y or other pla de Crei	natory	Da Marc	te ch 6,	20c. Lo	cation - City or	ville, PA
permit Depar Impor any In		21. Signature of Funeral Service Licer	man						man ru sville		1 Homes 21536	
Physician /Medical Examiner	S	23a. Part 1. Enter the disease, dr com shock, od beart failure. List only Immediate Cause (final disease or condition resulting in death)	plications that caused one cause on each line. a. Due to (or as build b	a conseque	Raw ence of):	e mode of dy	ing, such as	cardiac or	respiratory a	rrest,	/	Approximate Interval Between Onset and Death
te be executed ysician and he burial-transit	ical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as	Due to (or as a consequence of): Due to (or as a consequence of): CERTIFICATION APPROVED BY MEDICAL EXAMINER CERTIFICATION APPROVED BY MEDICAL EXAMINER								
he death certificate be e the attending physician thed for use as the buria	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ ∪nknown	23c. If yes, outcome 1 Live birth 4 Pregnant at 9 Unknown	2 Fetal	death 3 ☐ Ect	opic pregnan er <i>(specify)</i> _	су				23d. Date of de Month	l elivery Day Year
The law requires that the de are has been signed by the a bage 2 should be detached to	ed by Ph	Part II. Other significant conditions of	ontributing to death bu	ut not resul	ting in the underl	ring cause gi	ven in Part I	•		obacco u Yes 2[to the cause of death
	Completed by								24a. Was autop perfo 1 □ Yes		prior to death?	
Physician: The raths certificate ral director, peg	Be C	25. Was case referred to medical examiner? 1 Wes	Hospital:		R/Outpatient 3	□ DOA Oti			(Check only o		6 M Other (Cn	ecity) HOSPIC
To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director,	Certification: To	27. Manner of Death 1 Natural 5 Pending investigation 2 Accident 6 Could not b determined	28a. Date of Inju (Month, Da)	ry y, Year)	28b. Time of Injury	28c. Inju Wo 1 1 [No 28	3d. Describe	how injur	y occurred d Number or F	Rural Route Number,
To the Hospital of within 24 hours all to the Funeral Dominated to the Funeral Dominated tilled in the filled in t	Medical Ce	29a. Certifier 1 ☐ Certifying Pr (Check only one) 2 ☐ Medical Exar	nysician: To the best on the basis or and manner sta	f examinati	ledge, death occon and/or investi	urred at the t gation, in my	time, date ar opinion, dea	nd place, a	nd due to the d at the time,	cause(s)) and manner a d place, and du	as stated. le to the cause(s)
To the within To the compl	Me	29b. Signature and title of certifier				29c. Licen	se number	54		29d. Dat	te signed (Mon	ith, Day, Year)
وا St	VA ate	30. Name and address of person who Paul Daniel Mil 31. Date filed (Month, Day, Year)	completed cause of d	eath (Item	23a) (Type, Print R Acx ire	e Bith	ne (Dal	elan	1,	M	nth, Day, Year) -/20/7

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death MARY MARGARET BOWERS Physician/ 5:45 PM MARCH Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 5579 RICKELL Rd Carroll Taneytown, MD If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth Months | Days | Hours | Min. | Month, Day 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 9. Birthplace (State or Foreign 1 🗆 M 2 🗹 F 215-40-0514 Director Usual Residence of Decedent and Mental Hygiene. is marked other than "natural", or items 23a or 28a-f show aumatic event, the Medical Examiner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director Carroll MD Taneytown 1 Yes 2 No 10e. Street and Number 10g. Citizen of What Country? 5579 Rickell Rd. 21787 Funeral be filed within 72 hours after death with United States Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, White, etc. Specify: White 11. Marital Status 1 Never Married 2 Married Completed by Yes 2 No 21215-0036 1 ☐ Yes 2 ☑ No Specify: If Yes, Give Year or Dates 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Restaurant Elementary/Seconday (0-12) 10 Be Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Dorothy M. Tine Kreit t. Page 1 and 2 should be f tment of Health and Menta rtant: If item 27 is marked ijury or other traumatic ev George A. Kreit 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jack Bowers, Husband 5579 Rickell Rd, Taneytown, MD 21187 Baltimore, 20b. Place of Disposition (Name of 20a. Method of Disposition semetery, crematory, or other place)
St. Joseph Cath, Cem. March 9, Jost Taney-town, MD Department of Important: If i any injury or c 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licens yers-Durboraw F.H., 136 E. Baltimore St, Taney town, M 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate interval Between Onset and Death Immediate Cause (Final Pnysician/ DANCREMY (ANCER disease or condition resulting in death) METASTAN Medical Due to (or as a consequence of) Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter Ordenying Cause (Disease or linjury Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed signed by the attending physician and defeached for use as the burial-trans that initiated events resulting in death) Last Due to (or as a consequence of) Certificate: To Be Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 23d. Date of delivery Month Day Year 1 Yes 2 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? MUDERTENHON 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an within 24 hours after death.

To the Funeral Director: After this certificate has completed filled in by the funeral director, page 2 s performed? Yes 2 No 2 No 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital 2 No Other: 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident Investigation 6 Could not be 3 Suicide 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office bullding, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Registrar DHMH 17 Rev 7/2009

State

76

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

1 AJON A.

31. Date filed (Month)

TATE

one.

Registrar's Signature

29d. Date signed (Month, Day, Year)

3-5-12

21787

D43643

Fredericy St.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. AMEND 20B PER FH FCHD TM 3/8/12 State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month March 2012 JOHN 12:01 A M BONAN WILLIAM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Frederick Frederick Memorial Hospital Frederick 6. Sex 1 X M 2 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** (Month, Day, Days Hours Director 215-13-9870 41 1970 Washington, DC May Usual Residence of Decedent 28a-f show 10a. State 10b. County with the Maryland notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 ☐ No Knoxville Maryland Frederick 10e. Street and Number ō 10f. Zip Code 10g. Citizen of What Country? event, the Medical Examiner must be Funeral 23a 14 Evan Court 21758 USA items 2 72 hours after death 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Race - American Indian, Armed Forces? Black, White, etc. ò þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify. "natural", Completed 3 Widowed 4 Divorced Specify. White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) Sales Associate Retail Be Page 1 and 2 should be filed ment of Health and Mental Hy 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Linda Lucille Herbert John Bonan 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Michael Bonan / Brother 14 Evan Court, Knoxville, MD 21758 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 3/5/2012 1 ☐ Burial 2 🏋 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) cemetery, crematory or other place) Stauffer Crematory Frederick, Maryland 21. Sign vur of Funeral Service Licenses Stauffer Funeral Home 22. Name and Address of Facility 1621 Opossumtown Pike, Frederick, MD 21702 Pert 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failule. Ust only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ robable aute disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner oronary Sequentially list conditions Examine Due to (or as a consequence of) if any, leading to immediate cause. Enter Underlying The law requires that the death certificate be executed Cause (Disease or linjury that initiated events resulting in death) Last and burial-trai Due to (or as a consequence of): attending physiciar Physician/Medical Division of Vital Records, P.O. Box 68760 the IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Year Pregnant at time of death be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ ardio myo path 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Xunknown Completed page 2 should Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy within 24 hours after dea h.

To the Funeral Dir. ctor: After this certificate 1 Yes 2 No or Attending Physician: funeral director, 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) xaminer? 1 Yes Other: 2 No 1 Inpatient 2 ER/Outpatient 3 I DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of injury 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending 1 Yes 2 No filled in y the 2 Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number 4 Homicide determined City or Town, State)

State Registrar

3

completed

Medical

29a. Certifier

(Check

29b. Signature and title of certifie

Manuel

31. Date filed (Month, Day, Year)

To the Hospital

ST

MD

32. Registrar's Signature

400 W 7

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MD

Casiano

1 Ecertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

[Insert by the discontinuation of the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

DEP 35267

MD 21701

29d. Date signed (Month. Dav. Year)

03-01-2012

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

Frederick

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

ames Dennis B		y, Jr. St 1- For State Registrar	tate of Maryla		artment o <i>rtificate o</i> :		d Mental		2 0 Reg. No.	12 0897		
Physicia	ın/	Decedent's Name (First, Midd						Date of De Month		3. Time of Death 0453 hrs		
Medical Examir		James De 4a. Facility Name (if not institution	nnis]	Bailey,	Jr.	4b. City. Town, or	Location of De		26, 2012 4c. County of I			
		Frederick Memorial H	_			Frederick			Frederick			
Funeral		5. Social Security Number	6. Sex	7. Age (In yrs.	last birthday)	If Under 1 Year				9. Birthplace (State or oreign		
Director		220-21-9797	1 M 2 F	26	Yrs	Months Days	Hours	Min. July	10, 1985	Country)Maryland		
any	-	Usual Residence of Decedent 10a. State 10b. County		10c. City	, Town or Local	tion				10d. Inside City Limits		
≜		Maryland Free	derick		New Ma	rkot				1 Yes 2 X No		
Aaryland 28a-f show 1 at once.		10e. Street and Number	IELICK		New H	10f. Zip Code		I	10g. Citizen of What	: Country?		
eath with the Maryland items 23a or 28a-f sho ust he notified at once		5708 Kent Dri	ve			21	1774		United	States		
th with	Funeral	11. Marital Status 1 X Never Married 2 N	12. Was Dec			as Decedent of His es, specify Cuban				 Race - American Indian, Black, White, etc. 		
ter dea			1 Yes	2 X No	1	Yes 2X No	specify:		Specify:	White		
hours after fnatural", Examiner	d b	15. Decedent's Education (Spe	or Dates:		16a. Deceder	nt's Usual Occupat	ion (Give kind		16b. Kind of Busin			
9 2 and e contentary/secondary (6-12)										_		
5-0036 ted within 72 tygiene. other than '	E O	1.7. Father's Name (First, Middle	Last)		Human	Resource			Grocer , Maiden Surname)	y Store		
21215-0036 outd be filed within 7 is merted other than 8 marked other than it event, the Medica	Be C							, ,				
ID 21; should be and Men 7 is maric even	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Sta											
≥ da da mara da Z		James Dennis Bailey / Father 5708 Kent Drive New Market, Maryland 20a, Method of Disposition 20b. Place of Disposition (Name of cemetery Date 20c. Location - City										
Baltimore, permit. Pages I at Department of He Important: If ite		1 X Burial 2 Crematio		rom State	crematory or of	her place)	I	March 8,				
Baltimore permit. Pages 1 Department of H Important: If it	ŀ	4 Donation 5 Other S		La		Mem. Ga Name and Address		2012 Stauffer		lle, Maryland Homes, P.A.		
Depart Depart		WI &	2 Lito					Blvd. M	it. Airy,	Maryland 2177		
Physician /Medical		23a. Part I. Enter the disease of failure. List only one cause		aused the deat	h. Do not enter	the mode of dying,	such as cardi	ac or respiratory a	rrest, shock, or heart	Between Onset and		
Examiner	1	Immediate Cause (Final disease or condition resulting in death)		Intoxication						Death		
		Sequentially list conditions,	b.	a consequence	or).							
	je.	if any, leading to immediate cause. Enter Underlying Cause		a consequence	of):							
	Examine	(Disease or injury that initiated events resulting in death) Last	G	a consequence	of):							
50, te be executed ysician and burial - transit	E E	d.										
6 be ex ysician	edical	UNPENDED	AMENDED						23d. Date of de	alivon		
Division of Vital Records, P.O. Box 6876(the Hospital or Attending Physician: The law requires that the death certificate hin 24 hours after death. the Funeral Director: After this certificate has been signed by the attending phy- piletely filled in by the funeral director, page 2 should be detached for use as the b		IF FEMALE: 23b. Was decedent pregnant in t past 12 months?	the 1 Live t			etal death 3 [Ectopic pre	egnancy	Month Month	Day Year		
OX 6	Sici		4 Pregr death uknown 9 Unkn		5 O	ther (Specify)			40			
that the de ned by the detached f		Part II. Other significant condi			resulting in the	underlying cause g	iven in Part I.	23e. Did	tobacco use contribu	ite to the cause of death?		
, P.O res that to signed by be detace	Completed by							_ 1 _ Y	es 2 No 3	Probably 4 V Unknown		
ords, w requires should	lete								opsy prid	ere autopsy findings available or to completion of cause of		
Division of Vital Records, talor Attending Physician: The law requir rs after death. al Director: After this certificate has been sted in by the fameral director, page 2 should t	EO				-			per 1 ✓ Yes		ath? ✔ Yes 2 No		
Vital Reorsician: The his certificate director, page	Bec	25. Was case referred to medical examiner?			al .		of Death (Ch	· ·	7			
Physi Physi er this	은	1 Yes 2 No 27. Manner of Death	28a Date	Inpatient 2	28b. Time of		y at Work?	ursing Home 5 28d. Describ	Residence 6	Other:		
on of value Ph ath. or: After t	ţ	1 Natural 5 Per	iding FOUND	h, Day,Year)):	FOUND: 0351 hrs	1 1	res 2 ✓ No	Hinknown				
Visior or Attend frer death Director; in by the	ifica	2 Accident Inve	290 Place			et, factory, office b	uilding, etc.	28f. Location or Town.		or Rural Route Number, City		
Divi Hospital or 24 hours afte Funeral Dir tely filled in	Certification:	4 Homicide		Single Fa				4301 Bartho	olows Road, Mount			
To the Hos within 24 h To the Fur completely		Check only	•						use(s) and manner a te and place, and due			
To the within To the To the comple	Medical	29b. Signature and title of certifi	and manner			29c Licens				(Month, Day, Year)		
		ancto	>			O.C.I	M.E.		February 26,	, 2012		
0.	}	30. Name and address of perso	•									
3			sistant Medical		fund o		Baltimore,	MD 21223				
St Regist	ate	31. Date filed (Month, Day Year,	6 2012 32.8	egistrar's Signa	ture	arked						

OCME

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death . Decedent's Name (First, Middle, Last) 3. Time of Death 20^{Year} **Physician** 9:41 AM Carrie Maggie Boyer /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Kent Chestertown Chester River Manor If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2√□ F Months Days Hours MD 91 Director 218-22-8981 Usual Residence of Decedent and 2 should be filed within 72 hours after death with the Maryland 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 28a-f show Examiner must be notified at MD Kent Chestertown 1 ☐Yes 2 No Director 10f, Zip Code 10g. Citizen of What Country? 10e. Street and Number ò 8596 Caulkfield Rd. 21620 USA items 23a Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ▼No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 □ Never Married 2 □ Married Specify: Black Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No If Yes, Give Year or Dates: Specify. Completed by 3 X Widowed 4 □ Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) Give kind of work done during most of working life, DO NOT use retired) Private Family Elementary/Secondary (0-12) College (1-4or 5+) Domestic 8th of Health and Mental Hygic fitem 27 is marked other I r other traumatic event, Ib 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Helen E. Butler Gilbert A. Hynson ၉ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
8596 Caulkfield Rd Chestertown, Md 21620 19a. Informant's Name/Relationship (Type. Print) Irene Moore-Daughter 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date Pages 1 20a. Method of Disposition Department of H Important: If ite any injury or ot once. 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 3/10/12 Worton Point, MD St. George 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Kenneth Walley F.S. Forest Dr. Annapolis, Md 21401 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner wies of @ pelmi abscess dramage Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Due to (or as a consequence of): by Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 🗆 Ectopic pregnancy in the past 12 months? Month Day Year 5 ☐ Other (specify) 1 □Yes 2 □ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? DM OHON a Chrome Renel 1 ☐ Yes 2 ☐ NO 3 ☐ Probably 4 ☐ Unknown Completed advanced deg. arttints O Shoulde 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Episode of Sepsis (5) Demaritia 1 ☐ Yes 2 DNo 1 ☐ Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Medical Certification: To Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 ☐ Yes 1 Inpatient 2 ER/Outpatient 3 DOA 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred Injury 1 Natural

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the hurial-trancit Box 68760, of Vital Records, P.O.

5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

(Check only 29b. Signature and title of certifier

29a. Certifier

29c. License number

29d. Date signed (Month, Day, Year)

INK.

31. Date filed (Month, Day, Year)

D21313

KI hallen

WUN

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

and manner stated.

State Registrar

Washington Ave, Chestertown MD 21620

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ MARY CATHERINE BOYLES 7:00 P M MARCH 2012 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death CHESTER RIVER MANOR KENT CHESTERTOWN If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. Funeral Social Security Number 7. Age (In yrs. last birthday, 8. Date of Birth 9. Birthplace (State or Foreign 1 M 2X F Months 05/30/1920 Director 217-36-0228 MARYLAND 91 Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City, Town or Location with the Maryland 10d. Inside City Limits Director must be notified 1 X Yes 2 No KENT MD MILLINGTON 10e. Street and Number or 10f. Zip Code 10g. Citizen of What Country? by Funeral 23a 340 CYPRESS STREET 21651 UNITED STATES and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) of Health and Mental Hygiene. Item 27 is marked other than "natural", or iten other traumatic event, the Medical Examiner I 11. Marital Status 14. Race - American Indian Armed Forces Black, White, etc. 1 Never Married 2 Married Yes 2 XNo Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: If Yes, Give 3X Widowed 4 □ Divorced Specify: Completed Year or Dates WHITE 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 8 HOMEMAKER OWN HOME Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 HARVEY THOMPSON **FANNY CANNON** 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is any injury or other trau 340 CYPRESS STREET MILLINGTON, MARYLAND 21651 SHIRLEY COLEMAN / DAUGHTER Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Page 1 🗶 Burial 2 🗆 Cremation 3 🗆 Removal from State 4 Donation 5 Other (Specify) SUDLERSVILLE CEMETERY 03/08/2012 SUDLERSVILLE, MARYLAND Signature of Funeral Service License 22. Name and Address of Facility
FELLOWS, HELFENBEIN AND NEWNAM FUNERAL HOME, P.A.
130 SPEER ROAD CHESTERTOWN, MARYLAND 21620 Kuk 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cau con each Immediate Cause (Final Ohset and Death Physician/ disease or condition resulting in death) Medical ue to (or as a consequence of **Examiner** Sequentially list conditions, if any, leading to immediate Examine Due to (or as a consequence of): Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of) attending physician Physician/Medical certificate be P.O. Box 68760 the as IF FEMALE yes, outcome of pregnancy
Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 \(\sum \) Yes 2 \(\sum \) No 3 Ectopic pregnancy
5 Other (specify) ____ Pregnant at time of death Unknown Day ed by the a 9 Unknow صرد nas been signed by page 2 should be detacl Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I, 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy certificate 1 ☐ Yes 2 ☐ No Yes within 24 hours after death.

To the Funeral Director, After this certifics completed filled in by the funeral director, I Hospital or Attending Physician: 25. Was case referred to medica Be 26. Place of Death (Check only one) examiner? Hospital 2 No Other ဂ္ 1 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate; 28c. Injury 28d. Describe how injury occurred iniury 2 Accident 5 Pending work? 2 No Investigation M 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifie Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signati 29c. License number 29d. Date signed (Month, Day, Year) Name and address of person who com d cause of death (Item 23a) (Type, Print)

Registrar

DHMH 17 Rev 7/2009

State

10

01

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician/ Year 11:59 PM 2012 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death GENESIS CRESCENT RIVERDALL PG Age (In yrs. last birthday) 6. Sex 1 🕅 M 2 🗆 F 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 8/28/1941 Birthplace (State or Foreign Country) Funeral Months 411-62-8999 Director Tenness Usual Residence of Decedent 28a-f shov 10a State 10b. County 10c. City. Town or Location 10d. Inside City Limits Page 1 and 2 should be filed within 72 hours after death with the Maryland must be notified at Director MD Prince George's Fort Washington 1X Yes 2 ☐ No 10e Street and Number 5 10f. Zip Code 10g. Citizen of What Country? Funeral 23a 11907 Bizet Court 20744 items 12. Was Decedent Ever in U.S. Armed Forces?

1 X Yes 2 □ No If Yes, Give Year or Dates. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Race - American Indian, traumatic event, the Medical Examiner Black, White, etc 0 þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify "natural", 3 X Widowed 4 ☐ Divorced Specify: Black Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done life. DO NOT use retired) during most of working and Mental Hygiene. is marked other than College (1-4 or 5+) Elementary/Seconday (0-12) Federal Government years X-Rav technician Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Unknown Sadie Byrd 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Nina L. Coe/Daughter item 27 P.O. Box 1241 Waldorf, MD 20604 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Page 1
Department of
Important: If it
any injury or o 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Harmony Memorial Park 3/9/2012 Landover, MD 22. Name and Address of Facility Marshall-March Funeral Home 21. Signature of Funeral Service Licensee 4308 Suitland Road Suitland, MD 20746 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) CANCER ~Pnysician/ BRAIN Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of) Exami as the burial-transit Cause (Disease or linjury and that initiated events resulting in death) Last Due to (or as a consequence of) ed by the attending physician detached for use as the burial Physician/Medical The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) in the past 12 months? P Month Year Pregnant at time of death 2 No Unknown sate has been signed by page 2 should be detac Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by DISORDER 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy performed? Yes 2 No within 24 hours after death.

To the Funeral Director: After this certificate I completed filled in by the funeral director, pag To the Hospital or Attending Physician; 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: ၉ 1 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 Other (Specify) 27 Manper of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural
2 Accident 5 🗀 Pending work? 2 🗆 No Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Muse Bragitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certif 29d. Date signed (Month, Day, Year) 2/28/2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Huy, Riverdale MD20937 Husain, 4409

State Registrar 31. Date filed (Month, Day, Year)

DHMH 17 Rev 7/2009

mes

12-02100 Rory Ivan Borrero

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

ICasc	Type of I thic in Die	CK IIIGEIIDIE IIIK.	Lilouie All O	obica vic i
	State of Maryland /	Department of He	ealth and Ment	al Hygiene

2012 0898	08980
-----------	-------

, , , , , , , , , , , , , , , , , , , ,		1- For State Certificate of Death	and montanings	Reg. No.	012 0090
Physicia	n/	Decedent's Name (First, Middle, Last)	M	ate of Death lonth Day Ye	3. Time of Death
Medical Exami				arch 13, 2012 4c. County	0939 hrs
3		4a. Facility Name (if not institution, give street and number) 4b. City, Town 18311 Showater Road Hagersto	n, or Location of Death	Washin	
Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1		Date of Birth(MM/DD/YYY	9. Birthplace (State or
Director			Davis Harris Mar	April 10,1963	ForeignWashington, Country) DC
áu	-	10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits
nd Show	اج	Maryland Washington Hagersto	own		1 Yes 2 No
Aaryla 28a-f	Director	10e. Street and Number 10f. Zip Coo		10g. Citizen of W	
th the Maryland 23a or 28a-f sho notified at once.			42	USA	<i>A</i>
hours after death with the Maryland 'natural', or items 23a or 28a-f sh Examiner mast be notified at once	Funeral	11. Marital Status 1 Never Married 2 Married 1. Yes 2 No 13. Was Decedent Ever in U.S. 14. Was Decedent Survival In The Surviv	of Hispanic Origin? (Specify Suban, Mexican, Puerto Ricar		e - American Indian, Black, e, etc.
ral",	à	3 VVidowed 4 V Divorced in res, sive reel or Dates:		Specify:	White
	te d	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+)	g life. DO NOT use retired)	ione Tibb. Kirid of Bi	usiness/Industry
36 hin 72 e e dical	ple	12 Electric	-4		71 4 - 4 1
15-0036 filed within 72 I Hygiene. of other than "	Completed	12 Electric	18.Mother's Name (First	t, Middle, Maiden Surname	Electrical
21215-0036 and be filed within 72 Mental Hygiene. marked other than 'e event, the Medical	Be	Alfredo P. Borrero	Luz Mor	can	
NESEN	P	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (S	Street and Number or Rural I	Route Number, City or Tov	vn, State, Zip Code)
MD and 2 show alth and 27 is raumatic		Luz Borrero / Mother 7205 Adirona 20a. Method of Disposition 20b. Place of Disposition (Name	dack Dr. Fre	ederick, MD	2 1 7 0 2 - City or Town, State
Baltimore, MI permit. Pages 1 and 2 s Department of Health a Important: If item 27 injary or other traum		1 Burial 2 Cremation 3 Removal from State crematory or other place)			5.7 ,
ti. Pag tment rtant:	П	4 Donation 5 Other Specify: Stauffer Cremat. 21. A sture of Funeral Service Licensee 22. Name and Ado	A		rick. Marvland
Bal Bermi Depar injing	- 1	the desired state of the state		Stauffer Fund	
Physician	-	1621 On The Lenter the discusse, or complication that caused the death. Do not enter the mode of dy	OSSUMTOWN Pi ing, such as cardiac or resp	ike. Frederic biratory arrest, shock, or he	eart Approximate Interval
/Medical	-	failure. List only—fie cause on each line. Immediate Cause (Final disease a Hypertensive Cardiovascul.ar			Between Onset and Death
Examiner	- 1	or condition resulting in death) Due to (or as a consequence of):	DISCUSE		
		Sequentially list conditions, b			
	Ē.	if any, leading to immediate cause. Enter Underlying Cause Consequence of the cause			
_ =	Examine	(Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):			
60, ate be executed ohysician and te burial - transit			_/_12 cm		
60, ate be ex physician te burial	Medical	▼ UNPENDED	-4-12 SM		
876(ificate ig phy s the b			3 Ectopic pregnancy	23d. Date of Month	f delivery Day Year
Box 687 e death certific the attending of the the as the	icia	past 12 months? 4 Pregnant at time of death 5 Other (Specify)			·
Box 687 ne death certific the attending p	Physician/	1 Yes 2 No 9 Unknown 9 Unknown		OR BUILD	The base of death O
that th	출		ise given in Part I.		ribute to the cause of death? Probably 4 Unknown
Division of Vital Records, P.O. ral or Attending Physician: The law requires that it is after death. al Director: After this certificate has been signed by led in by the funeral director, page 2 should be detabled.	B				Were autopsy findings available
cords, law requir has been s	Completed			autopsy	prior to completion of cause of death?
Rec The l cate l	悥		1_	1 ✓ Yes 2 No 1	Yes 2 No
tal Rec	8	25. Was case referred to medical examiner?	Other Nursing Hor		Others Course
Physi Physi er this	의	1 Ves 2 No Impatient 2 Ervoutpatient 3 Don		me 5 Residence 6 Describe how injury occur	
on of ading Ph. th.: After ti	<u>:</u>	27. Manner of Death 1 Natural 5 Pending 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c.	Yes 2 No	- , ,	
isior Attencer death rector:	<u>i</u> g	Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, off	ice building, etc. 28f.	Location (Street and Numb	per or Rural Route Number, City
Divipital or ours after all Divipital Certification:	3 Suicide 6 Could not be determined (Specify)		or Town, State)		
To the Hos within 24 h To the Fur completely	Medical	one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opi and manner stated.			
	≨		.C.M.E.		ned (Month, Day, Year)
		Panile G Verthall (PP)	, O, IVI. E.	March 14,	~U I &
		30. Name and address of person who completed cause of death (Item 23a) Pamela E. Southall, MD Assistant Medical Examiner 900 W. Baltin	nore Street, Baltimore	e, MD 21223	
St	ate	31 Date filed (Month, Day Year) 32 Rehistrar's Signature			
Regist					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 1, Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Febonth. 2 Bay 2012 Albert Anderson Cooke, Jr. 4:10A Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death
Prince Georges **Examiner** 3735 Halloway North Upper Marlboro Social Security Number If Under 1 Year | If Under 24 Hrs. | 8, Date of Birth 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 244-26-7069 1 🖳 M 2 🗆 F Ma (Mo8h, 12927 84 Yrs North Carolina Director Usual Residence of Decedent 10a. State 10b County 10c. City. Town or Location 10d. Inside City Limits Director 1 Yes 2 No Maryland Prince George's Upper Marlboro 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20772 3735 Halloway North United States 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces Black, White, etc. 1 Never Married 2 Married þ 2 No If Yes, Give Year or Dates. 1 ☐ Yes 2XXX No Specify. Completed 3 Widowed 4 Divorced Black 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) U.S. Postal Service Postal Service Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Malden Surname) Albert A. Cooke, Sr. ည Mae Barnes Allie 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, 3735 Halloway North, Upper Marlboro, MD 20772 Ollie P. Cooke (Wife) 20a. Method of Disposition

↑ ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 3/12/2012 Cheltenham, MD 4 ☐ Donation 5 ☐ Other (Specify) Maryland Veterans Cemetery 21. Signatur of Funerel Servi Licensee 22. Name and Address of Facility Lee Funeral Home, Inc 6633 01d m0/39 Alexandria Ferry Road, Clinton, MD 20735 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death disease or condition resulting in death) Due to (or a a consequence of Sequentially list conditions, cause. Enter Underlying Cause (Disease or iinjury Examiner Due to for as a ponso swince. To that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Pregnant at time of death Day Year 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 【 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 2 🗌 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital 2 X No Other: 1 Yes ျှ 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify, 27. Manner of Death

Physician Medical Examiner attending physician and for use as the burial-transit law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760 been signed by the should be detached has e 2 page Hospital or Attending Physician: The certificate To the Hospital or Attendil within 24 hours after death. To the Funeral Director: Al completed filled in by the fu death.

28a-f show

5

items 23a

ō

"natural",

and Mental Hygiene. is marked other than

1 and 2 s of Health item 27

70

Department of Important: If it any injury or o once.

Page 1

death

72 hours after

Saltimore, Maryland 21215-0036

notified at

must be

Examiner

Medical

the

traumatic event,

1 Natural

3 ☐ Suicide 4 ☐ Homicide

only one

29b. Signature and title of certifie

Mariaileen

29a. Certifie (Check

Accident

5 Pending

Investigation

determined

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

6 Could not be

Certificate:

Medical

Registrar DHMH 17 Rev 7/2009 28b. Time of

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

M.D.

28c. Injury at work?

1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

3 🗌 Certifying Nurse Practioner. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

114 Defense How

1 Yes

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

D72591

2 🗌 No

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29d. Date signed (Month, Day, Year)

2/27/2012

Sle-400, Annapolis, MD

28a. Date of injury

(Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death Month 2 Physician/ Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death **Examiner** Washington Adventist Hospital Takoma Park Montgomery If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) If Under 1 Year **Funeral** Hours Director 72 579-52-3310 1 M 2 X F May 21,1939 West Virginia Usual Residence of Decedent show 10d. Inside City Limits 10b. County 10c. City, Town or Location with the Maryland at Director or 28a-f sh notified a 1X Yes 2 No Maryland Montgomery Takoma Park 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Numbe ō an "natural", or items 23a or Medical Examiner must be Funeral 20912 United States 6501 Poplar Avenue; Apt. 109 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) within 72 hours after death 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces?

1 Yes 2 X No
If Yes, Give Black, White, etc. 1 Never Married 2 Married Ď Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify **Black** 3 X Widowed 4 Divorced Completed Year or Dates Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4 or 5+) Domestic 9th grade Homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be t Department of Health and Mental Important: If item 27 is marked any injury or other-traumatic evo ပ Charles Brown Anavesta Barnes 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8801 Delphi Drive; Clinton, Maryland 20735 Ruth Angela Davis (Daughter) 20b. Place of Disposition (Name of 20a. Method of Disposition 20c. Location - City or Town, State cemetery, crematory or other place) 1 ื Burial 2 🗌 Cremation 3 🗌 Removal from State March 10,2012 Washington, D.C. 4 ☐ Donation 5 ☐ Other (Specify) Glenwood Cemetery 21. Signature of Vineral 22. Name and Address of Facility R. N. Horton Company Morticians, Service Licensee Inc.;600 Kennedy Street, N.W.; Washington, D.C. 20011 CC0333 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final , Physician/ disease or condition resulting in death) ocevoay Medical Due to (o a consequence of): **Examiner** Sequentially list conditions. if any, leading to immediate Due to (or as a consequence of): Examir To the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or injury inding physician and use as the burial-trans that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Box 68760 IF FEMALE yes, outcome of pregnancy □ Live Birth 2 □ Fetal death 3 □ Ectopic pregnancy 23b. Was decedent pregnant 23d. Date of delivery atter for u in the past 12 months? Month Day Year Pregnant at time of death the hed i 9 Unknown P.O. signed by tl d be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 Yes 2 No 3 Probably 4 X Unknown Division of Vital Records, Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 \(\subseteq \text{ Yes} \) 2 \(\subseteq \text{ No} \) 24a. Was an autopsy performed Yes 2 page 2 director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital: Other: 1 Yes 2 No 1 🗆 Inpatient ER/Outpatient 3 COA 4 Nursing Home 5 Residence 6 Other (Specify 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of I Director: After the funeral 28c. Injury at 28d. Describe how injury occurred Certificate: 1 X Natural 5 Pending work? 1 ☐ Yes 2 ☐ No death Accident Investigation 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide determined after within 24 hours a To the Funeral L Medical X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one 29b. Signature and title of 29c. License numbe 29d. Date signed (Month, Day, Year) who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year)

MAR 0 8 Registrar's Signature State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ riett uke Month Dav Medical **Examiner** 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Kris Leigh Assisted Living Severna Park Anne Arundel Age (In yrs. last birthday) **Funeral** If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year 9. Birthplace (State or Foreign Days 214-14-4776 Hours 91 **Director** 1 M 24 F Oct. 20, 1920 Maryland 28a-f show 10a. State 10b. County 10c. City, Town or Location must be notified at 10d. Inside City Limits Directo Maryland Anne Arundel Annapolis 1 Yes XX No 0 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 2506 Eastern Point Court items 23a 21401 U.S.A. 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black White etc "natural", or þ 1 Never Married 2 Married 1 Yes If Yes, Give 2 X No Baltimore, Maryland 21215-0036 Page 1 and 2 should be filed within 72 hours after White 1 ☐ Yes 2 X No Specify: Completed 3 Widowed 4 X Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) other than Elementary/Secondary (0-12) College (1-4 or 5+) Mental Hygiene. Administrator AFL-CIO Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 27 is marked or traumatic eve Colin F. Burch Harriett Eleanor Dent 19a Informant's Name/Relationship (Type, Print) Anne Adams/daughter 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 27 is 5462 Brooks Woods Road Lothian, Maryland 20711 Department of Health Important: If item 27 any injury or other th 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 XDBurial 2 Cremation 3 Removal from State All Saints Cemetery 3/9/2012 Oakley, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licens 22. Name and Address of Facility John M. Taylor Funeral Home 147 Duke of Gloucester St., Annapolis, MD 21401 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. nterval Between Onset and Death Immediate Cause (Final Physician/ ANOH MACIGNANT disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Que to for se a considuence on Cause (Disease or injury that initiated events attending physician and for use as the burial-trar Due to (or as a consequence of): resulting in death) Last Physician/Medical Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No signed by the atter Pregnant at time of death Month Day Year 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an this certificate has har ral director, page 2 s autopsy death? performe Yes 2 No **Division of Vital** Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital 1 ☐ Yes 2 ☐ No Other: ၉ 1 Inpatient 2 ER/Outpatient 3 4 Nursing Home 5 Residence 6 Other (Specify) the funeral 27. Manner of Death 28a. Date of injury Certificate: 28c. Injury at work? 28b. Time of 28d. Describe how injury occurred To the Hospital or Attending within 24 hours after death. To the Funeral Director: After (Month, Day, Year) 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) completely filled in by 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Description of the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) 30. Name and address se of death (Item 23a) Type ENSEHWY, ANNAPOLIS, M.D. ZIYO, ENE 6 31. Date filed (Month,

DHMH 17 Rev 06-2011

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 0 | 2 For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 02/28/2012 PHILLIP DARNELL DODSON 6:45 A Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death Clinton Prince George's Clinton Nursing & Rehabilitation Social Security Number If Under 1 Year If Under 24 Hrs. Sex 1XΩM2□F Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days Months Hours Min 08/16/1959 **Director** MD 220-76-6310 Usual Residence of Decedent or 28a-f show 10b. County 10a. State 10c. City, Town or Location with the Maryland 10d. Inside City Limits Director Prince George's Beltsville MD 1 X Yes 2 No 10e. Street and Number 10f. Zip Code ritems 23a or ner must be n ŏ 10g. Citizen of What Country? Funeral USA 20705 5434 Odell Road Page 1 and 2 should be filed within 72 hours after death ment of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or items 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces? Black, White, etc. b 1 X Never Married 2 ☐ Married Maryland 21215-0036 If Yes, Give 1 ☐ Yes Ž No Specify. 3 Widowed 4 Divorced Specify: Black Completed Year or Dates 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) the Switchboard Operator Hotel 12th Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) of Health and Mental H If item 27 is marked of r other traumatic ever ၉ Gertrude Elizabeth Morgan William Phillip Dodson, Jr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5434 Odell Road, Beltsville, MD 20705 William P. Dodson, Jr./father altimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) <u>+</u> 5 1 X Burial 2 Cremation 3 Removal from State Department of Important: If any injury or MD National Mem Pk 03/03/2012 Laurel, MD 4 ☐ Donation 5 ☐ Other (Specify) . Signature of Juneral Service License 22. Name and Address of Facility Snowden Funeral Home 246 N. Washington St, Rockville, MD 20850 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physiciani HIV/AIDS disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions. if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

Jo the Funeral Director: After this certificate has been signed by the attending physician and that initiated events resulting in death) Last Due to (or as a consequence of) signed by the attending physician and be detached for use as the burial-Physician/Medical P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 Yes 2 No 5 Other (specify) Month Day Year Pregnant at time of death 1 Yes 2 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? 9 Records, 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy performed? Yes 2X N 2 🗌 No 1 Yes **Division of Vital** eted filled in by the funeral director. 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 X No ည 1 Inpatient 2 I ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending Accident 1 ☐ Yes 2 ☐ No Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined edical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 03/02/2012 D65086 mos 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 106 Irving Street, NW, #201, Washington, DC 20010 Gordon O. Ramsay, MD

State

Registrar

31. Date filed (Month, Day, Year)

MAR 0 7 201

32. Registrar's Signature

2-01867 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Item State of Maryland 1500 Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Michael Dizebba Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death of maryland medical ch University Itimore Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) If Under 24 Hrs. **Funeral** 579-32-5717 Director 86 1 🛛 M 2 🗆 F Aug. 28, 1925 Usual Residence of Dec 28a-f show 10a. State 10b. County Examiner must be notified at 10c. City, Town or Location Director MD Charles LaPlata 10e. Street and Number ō 10f. Zip Code Funeral items 23a ll4 Hawthorne Green Circle 20646 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status rmed Forces? ö þ 1 Never Married 2 Married Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 🛛 No Specify: and Mental Hygiene.

is marked other than "natural", Completed 3 Widowed 4 Divorced the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 12 College (1-4 or 5+) Brick Mason Be 17. Father's Name (First, Middle, Last, 18. Mother's Name (First, Middle, Maiden Surname) Department of Health and Menta Important: If item 27 is marked any injury or other traumatic and once. မ Fiorvante DiZebba Gemma DiZebba 19a. Informant's Name/Relationship (Type, Print) Denise Quinn/Daughter Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)

10g. Citizen of What Country? USA 14. Race - American Indian. Black, White, etc. Specify: White

2012

Baltimore

4c. County of Death

Construction

20c. Location - City or Town, State

Cheltenham, MD

16b. Kind of Business/Industry

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 30115 Dudley Rd. Mechanicsville, Md. 20659

3/13/2012

1 🛣 Burial 2 □ Cremation 3 □ Removal from State MD. 4 ☐ Donation 5 ☐ Other (Specify) Signature of Juneral Service Licenses

22 Arenart-Echols Funeral Home, PA Box 567 LaPlata, Md.

23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)

0+ Complications Cervical Machi Due to (or as a consequence of)

Approximate Interval Between Onset and Death

943

10d. Inside City Limits

1X Yes 2 ☐ No

9. Birthplace (State or Foreign

PA

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

-0 Due to (or as a consequence on,

Due to (or as a consequence of):

CERTIFICATION APPROVED BY DICAL

IF FEMALE:

Physician/Medical 23b. Was decedent pregnant in the past 12 months?

1 ☐ Yes 2 ☑ No 9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___

Veterans Cem.

23d. Date of delivery Day

Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

1 Tes

c'et the tkns, dats and place, and due to the cauca(s) and manner ac stated

23e. Did tobacco use contribute to the cause of death? 2 No 3 □ Probably 4 □ Unknown

24a, Was an autops, performed a

Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☑ No

25. Was case referred to medical examiner? 1 Yes 2 No

27. Manner of Death

1 Natural 2 Accident

29a. Certifier

Suicide 3^rL Suicide 4 ☐ Homicide

Hospital M 28a. Date of injury (Month, Day, Year) 5 Pending

03/04/12

Inpatient 2 ER/Outpatient 3 DOA 28b. Time of injury 2000 PM

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28c. Injury at 1 🗌 Yes 20XN0

Other:

26. Place of Death (Check only one)

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State) 114 Hawthorne

 Place of Injury - At home, farm, street, factory, office building, etc. (Specify) home

Greene Circle, LaPlata, MD

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practitioner: To the boat of my included 29b. Signature and title of certifi

Investigation 6 Could not be

determined

29d. Date signed (Month, Day, Year) 03/05/12

Street Baltimore MD

21201

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed 32. Registrar's Sign

South

State Registrar

DHMH 17 Rev 06-2011

Physician/

Medical

burial-transi

the use as attending

be detached

page 2

filled in by the funeral director,

completely

within 24 hours after death.

To the Funeral Director, After this

and

physician

that the death certificate be

Records,

of Vital

Division

or Attending Physician:

Hospital

Examine

Completed by

Be

Certificate: To

Medical

Examiner

12-01630 Larry Robert Edgar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 08986 1- For State Certificate of Death Registrar 1. Decedent's Name (First, Middle,Last) 2. Date of Death 3. Time of Death Physician/ Month Day February 25, 2012 1651 hrs Madical Examiner Larry Robert Edgar c. County of Death 4b. City. Town, or Location of Death 4a. Facility Name (if not institution, give street and number) Bethesda Montgomery 4835 Cordell Avenue Apt. 1205 If Under 1 Year If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days Hours Director 218-76-1137 Country) 1 M 2 F 50 Yrs 03 03 1961 MD Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10h County 1 Yes 2 No Bethesda or 28a-f show MD Montgomery nours after death with the Maryland 10g. Citizen of What Country? 10e. Street and Numbe 10f. Zip Code 4835 Cordell Avenue Apt. 1205 20814 USA items 23a o ust be notifi 13. Was Decedent of Hispanic Origin? (Specify Yes or No- Race - American Indian, Black. 11 Marital Status 12. Was Decedent Ever in U.S. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Armed Forces White, etc. 1 Never Married 2 Married 1 Yes White 4 Divorced If Yes, Give Year Yes 2 No specify: Specify: 3 Widowed 含 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Completed ore, MD 21215-0036
s: 1 and 2 should be filed within 72 ho
af. Health and Mental Hygiene.
If them 27 is marked other than "na Elementary/Secondary (0-12) College (1-4 or 5+) the Medical private investigator self-employed 18 Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Robert Nelson Edgar Deloris E. Warnick 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 13403 Shearwater Place, Germantown, Connie J. Schroyer-wife MD 20824 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State crematory or other place) or other 1 Burial 2 Cremation 3 Removal from State Grantsville Cemetery 3/1/2012 Grantsville, MD 4 Donation 5 Other Specify 22. Name and Address of Facility David A. Burdock Funeral Home PA 21. Signa e of Funeral Service/Licensee 21 N 2nd St., Oakland, MD 21550 If I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval Physician Between Onset and lure. List only one cause on each line /Medical Death Combined effects of heroin cocaine and ethanol Immediate Cause (Final disease **Examiner** or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions. Due to (or as a consequence of) Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): pue 뗭 AMENDED 23a, 27, 28a-f, per me, g925 3-23-12 sm X UNPENDED physician the burial Physician/Medi The law requires that the death certificate be 23d. Date of delivery 23c. If yes, outcome of pregnancy IF FEMALE 23b. Was decedent pregnant in the 2 Fetal death 3 Ectopic pregnancy Month Day Year past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ 1 Yes 2 No 3 Probably 4 V Unknown Completed 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of has death? page 2 performed? Yes 2 No 2 No 1 🗸 Yes 26.Place of Death (Check only one) 25. Was case referred to medical Be Hospital: 1 Inpatient 2 ER/Outpatient 3 Other Nursing Home 5 Residence 6 🗸 Other: Scene DOA this 1 Yes 28c. Injury at Work? 28d. Describe how injury occurred 28a. Date of Injury 28b. Time of Injury 27. Manner of Death

Box 68760, Division of Vital Records, P.O. After the

1 Natural

2 ___ Accident

Suicide

Homicide

29b. Signature and title of certifier

30. Name and address of person

Melissa Brassell, MD

3 💹

4

who completed cause of death (Item 23a) Assistant Medical Examiner

Registrar's Signature

and manner stated.

fd 2-25-12

(Specify) Residence

900 W. Baltimore Street, Baltimore, MD 21223

29c. License number

O.C.M.E.

1 Yes 2 X No

unknown

28f. Location (Street and Number or Rural Route Number, City or Town, State) **4835 Cordell Ave.**Apt 1205 Bethesda, Md.

February 26, 2012

29d. Date signed (Month, Day, Year)

COME

Pending

6 X Could not be determined

Investigation

ORIGINAL

fd 4:51 pm

29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

28e. Place of Injury - At home, farm, street, factory, office building, etc

State Registra

		_ For	Plea	se Type or State of							All Copie Mental Hy		_	ible.		
	_	State Registrar					Certifica					Reg.	20	12	089	87
Physicia	n/	1. Decedent's Nam		,							2. Date of D Month		Day	Year	3. Time of D	
Medic Examin		EDWARD R 4a. Facility Name (if		give street and numb	ber)		4b. C	4b. City, Town, or Location of Death					3. 2012 10:20			P
		SAFE HAV						LERSV			QUEEN ANNE'S			E'S_		
Funeral Director		5. Social Security N		6. Sex 1 X M 2 □ F	M 2 \square F 7. Age (In yrs. last birthday) 1		Mont	der 1 Year is Days	If Unde Hours	Min.	8. Date of B (Month, D	av. Yea	7.0	Cour	place (State or F	oreign
*		215-16-3 Usual Residence of	Decedent			<u> </u>			<u> </u>		05/23	/19	18	MAK	YLAND	
ryland -f show ied at	ctor	10a. State	10b. County				or Location								10d. Inside City	
with the Marylan 23a or 28a-f sh 1st be notified a	Director	MD 10e. Street and Nur		ANNE'S	CHE	STER'		Zip Code				10a	Citizen of V	What Cour		IA NO
s 23a ust be	Funeral	120 FEY	ROAD				2	1620					ITED			
72 hours after death with the Maryland ""natural", or items 23a or 28a-f sho fedical Examiner must be notified at	þ	11. Marital Status		12. Was Deced	ces?	If You angift Culpan Maying Duante Disease at 1							. Race - American Indian, Black, White, etc.			
s after al", or Exami		1 Never Marr 3 X Widowed		If Yes, Give	9	37-78 1 ☐ Yes 2 🛣 No Specify: Specify:										
hour "natur	Completed	(Spe		it's Education st grade completed)	1731	16a. [Decedent's U Give kind of	sual Occupa	ation	et of work	ina	16b	. Kind of Bu			
thin 72 ane. than '	Som	Elementary/Sec		College (1-4	4 or 5+)	- h	ife. DO NOT	use retired)	_		_	MT	LITAR	v		
I be filed within 7 lental Hygiene. rked other than tic event, the M	Be	17. Father's Name (First, Middle, L	ast)		PIAK	ILAND	NATIO			e (First, Middle					
should be file and Mental H 7 is marked o raumatic eve	욘	WALTER E	LBURN						MARY	REBI	ECCA RI	NGG	OLD			
i and 2 should be filed within 72 hour f Health and Mental Hygiene. Item 27 is marked other than "natu other traumatic event, the Medical		19a. Informant's Na		ip (Type, Print)		19b.	Mailing Addr	ess (Street a	and Numb	ber or Rura	al Route Numb	er, City	or Town, S	tate, Zip (Code)	
1 and 2 s if Health item 27 other tra		20a. Method of Disp	<u>-</u>	SON	20b		04 CHU Disposition (f		ILL :		CHESTE Date		WN, M		AND 2162	20
age 1 ent of nt: If ii		1 🗌 Burial 2	X Cremation 5 ☐ Other (S)	3 Removal from Specify)	State	cemetery	, crematory o	r other plac	· .			1		-	, MARYL	A NTD
permit. Page 1 a Department of F Important: If ite any injury or ot once.		21. Signature of Fu			<u> </u>	IESAF									HOME, P	
8 3 E E 8		Kull	Alpe	phon			130	SPEER	ROAL) CHE	STERTOV	W.	MARYI	AND	21620	• A •
		23a. Part 1. Enter t shock, or hea Immediate Cause (rt failure. List oi	omplications that cannot one cause on each	th line.				g, such as	s cardiac o	or respiratory a	rrest,			Approximate Interval Betwe Onset and Dea	
hysician/ Medical		disease or condition resulting in death)		a. PROP	FOUND or as a conse	l De	bilit	7						-		
Examiner		Cognoptially list on	anditions.	Fai	lune	to	THAIV	e								
p t	Examiner	Sequentially list co if ally, leading to in cause. Enter Unde	rlying	Due to (o	lure on fatt	quanes of): -									
executed ian and irial-transit	Exar	Cause (Disease or that initiated event: resulting in death)	s	c. Due to (c	or as a conse	quence of	ance	K.						_	* * * * * * * * * * * * * * * * * * * *	
s be e) /siciar e buris	ical		(d												
ath certificate be attending physici for use as the bu	Physician/Medica	IF FEMALE:		T			_					_				
ath cer attend for use	cian/	23b. Was decedent in the past 12 j	months?		ome of pregr Birth 2 - Fe ant at time o	tal death	3 Ectop		у				23d. Dat	te of deliventh	ery Day Yea	ar
y the a	hysi	1 Yes 2 9 Unknown		9 Unkno		dealli	J L Other	(Specify)								
				ns contributing to de							23e. Did	tobacc	o use contr	ibute to th	ne cause of deat	th?
een sig	Completed by	MZheir	yen's	Sireone Fuchve teny D	1 1		6 .			_	1 🗆	Yes	2 🗆 No	3 🏻 Prol	bably 4 🗷 Un	known
has b	mple	CHRONE	-0517	Fuch Ve	Hulm	onau	y sex	esal		11	24a. Was	s an opsy formed'	i p	Vere autop prior to co death?	psy findings ava mpletion of cau	ilable se of
in: The ificate or, pag		25. Was case referre	ed medical	Teny 1	ness	e M	nd Co	Wyork V	e Fo	ellene	1 Tes			Yes	2 🗆 No	
is cert direct	To Be	examiner?	No	Hospital:	npatient 2	☐ ER/Outr	patient 3 🗆	Othe				idence	6 Othe	er (Specify	CARe	Haus
ing Ph		27. Manner of Death	5 Pending	28a. Date o	of injury or, Day, Year)	28b. Tir inj	me of ury	28c. Injury work	at		28d. Describe				, <u>, , , , , , , , , , , , , , , , , , </u>	
death death stor: A	Certificate:	2 Accident 3 Suicide	Investig	ation not be	of Injury - At I	omo form	M stroot foot		Yes 2	No	00(1 4'	(0.4			D- 1-11 1	
al or A s after I Direct d in by	Cer	4 Homicide	determi		g, etc. (Speci		n, street, ract	ory, office			City or To			er or Hurai	Route Number,	
Hospital 24 hours 5 Funeral I	Medical	29a. Certifier 1 (Check 2	Certifying	Physician: To the be xaminer: On the basis	st of my know	wledge, de	eath occured	at the time,	date and	d place, an	id due to the c	ause(s)	and manne	er as state	ed.	or stated
thin 24	Me	only one) 3	Certifying	Nurse Practioner: To	o the best of r	ny knowle	dge, death oc	curred at the	time, dat	te and place	e, and due to t	he caus	e(s) and ma	nner as st	ated.	er Stateu.
J_ 		▶ O	0 0.	shel C	154	1.1.	1			7			Date signed			
+		30. Name and addre	ess of person w	vho completed cause	of death (Ite	m 23a) (Ty	pe, Print)		/		afour		101	12		
ihs		John C.	ARRA	BM TR	M.d.	223	ibyh	Street	t, ch	lerte	nfour	, h	us.	214	20	
Stat Registra	e ir	31. Date filed (Monti	n Day, Year)	2012 32. Re	istrar's Sign	ature .	A Design									
				100	A COLUMN TO THE PARTY OF THE PA		" E"									

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Rodell Ford State of Maryland / Department of Health and Mental Hygiene 2012 08988 1- For State Certificate of Death Reg. No Registrar 1. Decedent's Name (First, Middle,Last) Physician/ 2. Date of Death 3. Time of Death Month Day February 29, 2012 Medical Examiner 1952 hrs Rodell S. Ford 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Anne Arundel Medical Center Annapolis Anne Arundel 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or **Funeral** Director Months Davs Hours 62 common yland 212-52-4601 1X M Dec 2 1949 2__F Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 28a-f show Maryland Anne Arundel Annapolis 1 Yes 2 X No death with the Maryland 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 106 D Clay St. 21401 USA 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Armed Forces? 1 X Never Married 2 Married Yes Specify: Black 3 Widowed 4 Divorced If Yes, Give Year 1 Yes 2 X No specify: 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) Anne Arundel Elementary/Secondary (0-12) College (1-4 or 5+) 77 st and 2 should be filed within 72 of Health and Mental Hygiene.

If item 27 is marked other than Baltimore, MD 21215-0036 10th General Hospital Dietary 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) Charles Ford Sr Alice Paige 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Verna Bean(Sister) Md. 21401 189 Clay St. Annapolis, 20b. Blacesof Disposition (Name of cemetery, 20a. Method of Disposition 20c. Location - City or Town, State crematory or other place)
Memorial Park 1 X Burial 2 Cremation 3 Removal from State 3 - 8 - 12Annapolis, Md. 4 Donation 5 Other Specify: 21. Signature of Funeral Service Licenses ²WMm^{e ar}R性性等色 Facility Sons Mortuary, 1922 Forest Dr. Annapolis, Md. 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval **Physician** failure. List only one cause on each line een Onset and /Medical Death Atherosclerotic Cardiovascular Disease Immediate Cause (Final disease xaminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions if any, leading to immediate Due to (or as a consequence of): eause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of) events resulting in death) Last and Physician/Medical $\mathbf{x}_{\mathsf{AMENDED}}$ 1 as noted,23a,pt.II,27,per me,g925 3-29-12 sm ysician a X UNPENDED The law requires that the death certificate be Box 68760 attending physicor use as the bu IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the 1 Live birth 3 Ectopic pregnancy Fetal death Month Day past 12 months? Pregnant at time of death Other (Specify) 1 Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, P.O. Cancer of stomach, bone 1 Yes 2 No 3 Probably 4 V Unknown Completed 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of performed? death? ✓ Yes 2 No 2 No 1 Yes 26.Place of Death (Check only one) 25. Was case referred to medical Division of Vital Be examiner? Hospital: 1 Inpatient Other Nursing Home 5 Residence 6 Other 2 ER/Outpatient 3 DOA this 1 🗸 Yes 2 No 27, Manner of Death 28a. Date of Injury (Month, Day, Year) After 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 1 X Natural Director: 1 Yes 2 No within 24 hours after death.

To the Funeral Director: Pending 2 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City 3 Suicide Could not be or Town, State) determined 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c, License number O.C.M.E. March 1, 2012 30. Name and address of person who completed cause of death (Item 23a) Olo Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223 Melissa Brassell, MD 31. Date filed (Month State istrar's Signature

DHMH 17 Rev 1/2001

Registrar

OCME

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 🤈 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ 7PM Carole A. Fuss MAKEL Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Hospital N mondia 21 hours 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** Days Min (Month, Day, Year) 096-32-3410 Months 1 🗆 M 2 🕱 F Director 69 May 1, 1942 New York 28a-f show 10d. Inside City Limits 10b. County 0a. State 10c. City, Town or Location ms 23a or 28a-f sho must be notified at Director Westminster Carroll Maryland 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21157 Funeral 910 Fowler Road USA 12. Was Decedent Ever in U.S.
Armed Forces?
1 ☐ Yes 2 No
If Yes, Give
Year or Dates. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status 2 should be filed within 72 hours after deat the and Mental Hygiene.
27 is marked other than "natural", or iter traumatic event, the Medical Examiner I Black, White, etc. 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Specify: white Completed 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Law Firm Secretary 12 nous as Carde Ame Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Albert Goodis Natalie Rembis 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 910 Fowler Road, Westminster, MD 21157 Terry R. Fuss, husband item 27 or other 20a. Method of Disposition 20b. Place of Disposition (Name of South Dematory or other place) Date 20c. Location - City or Town, State permit. Page 1 Department of Important: If it any injury or o 1 Burial 2 X Cremation 3 Removal from State 3/3/2012 Winfield, MD Carroll Crematory 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Licensee 22. Name and Address of Facility Myers-Durboraw Funeral Home Westminster, MD 21157 91 Willis Street, Enter the disease, or complications that caused the death. Do not enter the mode of dying, or heart failure. List only one cause on each line. Interval Between Opset and Death Immediate Cause (Final Physician | Due to (or as a consequence of): disease or condition resulting in death) Medical Examiner tastetic Sequentially list conditions, cause (Disease or injury tor: After this certificate has been signed by the attending physician and the funeral director, page 2 should be detached for use as the burial-transit ((hosis that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physicis completely filled in by the funeral director, page 2 should be detached for use as the burn completely filled in by the funeral director, page 2 should be detached for use as the burn. Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Day Pregnant at time of death g Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Were autopsy findings available prior to completion of cause of 24a, Was an autopsy death? performed?

Yes 2 No 1 Yes 2 XNo Be (25. Was case referred to medical 26. Place of Death (Check only one) Hospital 1 ☐ Yes 2 No ည 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural
2 Accident
3 Suicide
4 Homicide (Month, Day, Year) injury work? 1 ☐ Yes 2 ☐ No 5 Pending Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifie 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 0 1. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 1150 M Charles Stoner Fleagle 3 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Carroll Hospital Center Westminster Carroll Birthplace (State or Foreign Country) Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth Funeral (Month, Day, Year) 219-14-9944 92 Director 1 🗶 M 2 🗆 F Feb 19, 1920 Maryland Usual Residence of Deced nan "natural", or items 23a or 28a-f show Medical Examiner must be notified at 10c. City, Town or Location 10a. State 10d. Inside City Limits the Maryland Director 1 Yes 2 No Carroll Westminster Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21158 2500 Mayberry Road USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Was Decedent Armed Forces?

The Yes 2 ■ No 14. Race - American Indian, Black, White, etc. ģ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 No Specify: 3 Widowed 4 Divorced Specify: Completed white 16a. Decedent's Usual Occupation
(Give kind of work done during most of working Decedent's Education 16b. Kind of Business/Industry 1 and 2 should be filed within remof Health and Mental Hygiene.
If item 27 is marked other than "n (Specify only highest grade completed) life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Agriculture 11 Farmer Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Edgar Koons Fleagle Marie Stoner 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is any injury or other trau Peggy F. Keeney, daughter 3055 Mayberry Road, Westminster, MD 21158 20a. Method of Disposition 20c. Location - City or Town, State Date 20b. Place of Disposition (Name of Emmanuo wat Bausser place) 1 Burial 2 Cremation 3 Removal from State 3/7/2012 Tyrone, MD Church Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Myers-Durboraw Funeral Home 21. Signature of Funeral Service Licensee 136 E Baltimore St, Taneytown, MD 21787 23a. Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between SMALL BOWEL OBSTRUCTION Immediate Cause (Final Onset and Death Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) *Examiner Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of) Exami Cause (Disease or injury that initiated events resulting in death) Last and Due to (or as a consequence of) physician Physician/Medical that the death certificate be Box 68760 the attending IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?

1 Yes 2 No Month Dav Year Pregnant at time of death P.0. signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>S</u> FIBRILLA TION Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 has autopsy performed After this certificate 1 Yes Hospital or Attending Physician: 24 hours after death. Funeral Director: After this certific 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 1 No ည 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA funeral 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 5 Pending 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide
4 Homicide Accident Investigation completely filled in by the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year, D 30263

DHMH 17 Bev 06-2011

Registrar

13

backs

200 MEMORIAL AVE, WESTMINSTER, MD 2115

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

PANCIS KHUO, MD 200 MEMORIAL

6 201

32. Registrar's Signature

			Plea amend	ase Type or Pring #8 Per FH G9	nt in Blace 25, 3/27	k In	delible Ink	c. Ensure A	All Copies	Are Le	gible.		
		-	For State Registrar	Otate of Ma	arylarid / L		tificate of D			Reg. No. 2012 08991			
ı	Physicia Medic		1. Decedent's Name (First, Middl	e, Last)	Fu	CT	No		2. Date of Dea	2. Date of Death Month Day Year 3. Time of Death 1 - OAN			
	Examin	er	4a. Facility Name (if not institution 1405 Viers	-		4b. City, Town, or Location of Death Hanover					ty of Deat Arı	ndel	
	Funeral Director		5. Social Security Number 204-32-4435 Usual Residence of Decedent	6. Sex 7. Age	(In yrs. last birt	hday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Montal Day 08/ 98		9. Birl	thplace (State or Foreign untry)	
	rland f show d at	tor	10a. State 10b. County		10c. City, Towr		ation		10d, Inside City Limits				
	ne Man or 28a-i notifie	Director	MD Anne 10e. Street and Number	Arundel	Hanov	ver	10f. Zip Code		Т	10g. Citizen o	f What Co	1 🗌 Yes 🗶 🗆 No untry?	
	h with t ns 23a nust be	Funeral	1405 Viers L				2107			USA			
920	1 and 2 should be filed within 72 hours after death with the Maryland of Health and Merital Hygiene. item 27 is marked other than "ratural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	þ	11. Marital Status1 ☐ Never Married 2 ☐ Ma3 ☐ Widowed 4 ☐ Divorced	If You Cive		If	Vas Decedent of His Yes, specify Cubar	n, Mexican, Puerto	ecify Yes or No- Rican, etc.)	В	14. Race - American Indian, Black, White, etc. Specify: Black		
21215-0036	72 hou n "natu Aedical	Specify: Black Specify: Black Speci											
212	within ygiene. her tha ht, the h	6											
land	be filed lental H rked ot lic ever	To B											
Maryland	should h and N 7 is ma traumai		State, Zip										
re, l	1 and 2 of Healt item 2		Kenneth Fult 20a. Method of Disposition		20b. Place of	f Dispos	Viers		anover Date	20c. Location			
Baltimore,	permit. Page 1 a Department of I Important: If ite any injury or ot	1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee. 22. Name and Address of Facility Chass											
Ba	permi Depar Impol any ir	(5	21. Signature of Funeral Service Licensee 22. Name and Address of Facility Chestertown Bennie Smith FH 855 High St. MD 21620										
	Physician/ Medical		23a. Part 1. Enter the shease, o shock, or heart failure. List Immediate Cause (Final disease or condition resulting in death)	only one cause on each line	010	Cf	the mode of dying		or respiratory arr	rest,		Approximate Interval Between Thet an Douth	
a code	Examiner	_	Sequentially list conditions,	b.	a consequence	01).					- 1		
	red nsit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a	a consequence	orj.							
	e executed ian and urial-transit	al Exa	that initiated events resulting in death) Last	Due to (or as a	a consequence	of):							
09289	icate be physicas the bi	ledica		d									
Box 68	Physician: The law requires that the death certificate be this certificate has been signed by the attending physici ral director, page 2 should be detached for use as the bu	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome 1 Live Birth 4 Pregnant a 9 Unknown	2 Fetal deatl		Ectopic pregnand Other (specify)	су			Date of de Month	lîvery Day Ye ar	
P.O.	s that the gned by be detail	by Pr	Part II. Other significant condit	ions contributing to death b	ut not resulting	in the u	nderlying cause giv	ven in Part I.				the cause of death?	
ords,	requires that been signed k should be det	leted							1 🗆			robably 4 Unknown	
Reco	The faw ate has page 2	Completed							autor perfo 1 \(\sum \) Yes	rmed?	death?	completion of cause of	
of Vital Records,	ysician: The law r is certificate has k director, page 2 s	Be	25. Was case referred to medica examiner? 1 Yes 2 No	Hospital:	- 1 0 T FD/0	L Line	Othe	ace of Death (Chec		0 0			
0	ding Phys h. After this funeral d	ite: To	27. Manner of Death 1 ✓ Natural 5 ☐ Pend	28a. Date of inju	ent 2 ER/Ou ry 28b. 7 v, Year)	utpatien Time of injury	28c. Injury work	y at	ome 51 Residence 128d. Describe h			orty)	
Division	tten deat stor: y the	Certificate:	2 Accident Invest 3 Suicide 6 Could	tigation d not be 28e. Place of Inju		arm, stre		Yes 2 ☐ No			ber or Ru	ral Route Number,	
Div	oital or urs afte eral Dire			building, etc					City or Tow				
	To the Hospital or A within 24 hours after To the Funeral Direc completely filled in b.	Medic	29a. Certifier (Check only one) 29a. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.										
			29b. Signature and title of certific	er A. A. A. C.	. 0	0	29c. License	e number		29d. Date sign	ned (Mont	h, Day, Year)	
	3		30. Name and address of person	who dompleted cause of d	eath (Item 23a)	Type, P	rint) - nc	GC NC	= 141	V 1.	112	3615, M.D.2140	
	Sta	te_	31. Date filed (Month, Day, Year)	32. Regist	ar's Signature	4	A CONTRACTOR OF THE PARTY OF TH	1, 602	C 110	1, VTN	DIONE	0(15,17.0.2140)	
	Decision		陳太 泉	- 7 7017 N		100	1						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Elizabeth Physician/ Forbes Month 9:45 A M March 5 201 Medical 4a. Facility Name (if not institution, give street and number)
4907 Sweden Ct 4b. City, Town, or Location of Death ClintonExaminer 4c. County of Death George Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 215-52-3176 Days Months Hours March 28, 1942 Virginia **Director** 1 □ M 2 🕇 F 69 28a-f show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. 10a. State Prince George 10c. City, Town or Location 10d. Inside City Limits Director Clinton must be notified 1 🗌 Yes 2 🔀 No ö 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral U.S.A. 4907 Sweden Ct 20735 items 23a 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc Completed by "natural", or 1 Never Married 2 XMarried 1 ☐ Yes 2 😿 No If Yes, Give Baltimore, Maryland 21215-0036 Specify: Black 1 ☐ Yes 2X No Specify. 3 Widowed 4 Divorced Year or Dates Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) r than ". Elementary (6-12) College (1-4 or 5+) Manager Services Ith and Mental Hygiene
27 is marked other the
r traumatic event, the Be 17. Father's Name (First, Middle, Last)
Booker I Washington 18. Mether's Name (First, Middle, Maiden Surname) Nannie Henley ပ 19a. Informant's Name/Relationship (Type, Print)
Marion Anderson(Daughter) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4907 Sweden Ct Clinton Md 20735 : If item 27 i or other tra 20a, Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place Heritage Cemetery 20c. Location - City or Town, State Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Department o Important: If any injury or once. ō 3/10/2012 Waldorf Md Signatur of Funeral Service License 22. Name and Address of Facility atimore Funeral Service 2818 E Baltimore St Daltimore Md 21224 alems 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate shock, or heart failure. List only one cause on each line Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition arcing d ear Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): the burial-tran resulting in death) Last Due to (or as a consequence of): physician Physician/Medical il or Attending Physician: The law requires that the death certificate be a sitter death. Division of Vital Records, P.O. Box 68760 as attending IF FEMALE: nse 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 months? be detached for Day Year Pregnant at time of death 2 X No a 🗌 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autops Director: After this certificate 1 Yes 2 X No Yes 2 K XNO filled in by the funeral director, To Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital 2 X No Other: 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 X Watural 5 Pending injury. work? 2 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, ☐ Homicide determined To the Hospital o within 24 hours af To the Funeral Di Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completely Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 🛪 Cerftifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one

State Registrar

5

29b. Signatu

31. Date filed (Month, Day, Year)
MAR U 8 2012

9200 Baril

ho completed cause of death (Item 23a) (Type, Print) ANP-BC

32. Registrar's Signature

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 2<u>012</u> Physician/ Raymond E. Georges 2:15 РΜ March 6 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death 330 Brant Rd. Swanton Garrett 5. Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth Funeral 1 🕱 M 2 🗆 F Days Min Nov. 16, ^{Year}1927 203-22-8640 84 Pennsylvania Director Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits within 72 hours after death with the Maryland event, the Medical Examiner must be notified at Director 1 Yes 2 No MD Garrett Swanton 23a or 2 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 330 Brant Rd. 21561 USA or items 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc þ 1 Never Married 2 Married 1 X Yes 2 □ No If Yes, Give TATE Baltimore, Maryland 21215-0036 1 ☐ Yes 2 😾 No Specify: Specify: "natural", 3 Widowed 4 X Divorced Year or Dates. WW2 White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Whole Sale Supervisor permit. Page 1 and 2 should be filed wil Department of Health and Mental Hygie Important: If item 27 is marked other any injury or other traumatic event, th Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Frances Szymborski Gust Georges 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sarah Keller/Sister 1403 Sugar Run Rd., Venetia, PA 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place. 1 X Burial 2 Cremation 3 Removal from State Queen of Heaven Cem. March 10, 2012 McMurray, PA 4 Donation 5 Other (Specify) 22. Name and Address of Facility Newman Funeral Flomes, P.A. P.O. Box 275, Grantsville, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Atherascleratic Cardia vaser Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to for as a consequence of To the Hospital or Attending Physician: The law requires that the death certificate be executed and -trans that initiated events Due to (or as a consequence of) resulting in death) Last signed by the attending physician and be detached for use as the burial-Physician/Medical P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 months? Pregnant at time of death 2 No 1 Yes 2 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Division of Vital Records, been si should I Completed Were autopsy findings available 24a. Was an autopsy performed? Yes 2 No prior to completion of cause of death? has le 2 this certificate 2 No 1 Yes 25. Was case referred to medica Be 26. Place of Death (Check only one) Hospital Other: 2 No 1 🗌 Yes ဂ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Nesidence 6 ☐ Other (Specify) within 24 hours after death.

To the Funeral Director: After thi
completed filled in by the funeral 27. Manner of Death 28a. Date of injury 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) 1 X Natural 5 Pending work? 1 ☐ Yes 2 ☐ No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. only one) Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signat 29c. License number re and title of cert 30035 30. Name and address of person eled cause of death (Item 23a) (Type, Print) MEMORIAL CIVE 1027 NAW ichter MO 2 31. Date filed (Month, Day, Year, State

Registrar

Division of Vital Records, P.O. Box 68760,
To the Hospital or Attending Physician: The law requires that the death certificate be execu
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director name 2 should be detached for use as the burial-tra

			Please						k. Ensure A	-			le.		
		For State Registrar		State) iviar	yianu /	•	rtment of tificate of	Health and Death	wentai H	ygiene Reg. No	0.0	12	0.8	991
		Decedent's Nam	ne (First, Middle, La	ıst)						2. Date of D	ate of Death 3. Time of Death				
Physicia /Medic		G	DWNIE	- 5u	d	6	5-u	1/10	+	Wonth 3	Da C		Sear L	083	6 M
Examin		4a. Facility Name ((If not institution, giv			1400	trel	4b. City, Town,	or Location of Deat	h		. County o	- 1	+	
Funeral Director		5. Social Security N 215-68-65		Sex 1 □ M 2 X F	7. Age (in yrs. last b 54	oirthday) Yrs.	If Under 1 Year Months Days		8. Date of B (Month, L Aug • 2	irth Day, <i>Year)</i>	957 E	9. Birthpla Country Penns	ce (State o	r Foreign ia
nd ×		Usual Residence o	of Decedent 10b. County		1	Oc. City, To	wn or los	action					1100	d. Inside Cit	ty Limite
/anyla	o					McHen		auon							2⊠No
r 28a-	Director	MD 10e. Street and Nu	Garrett			Menen	τy	10f. Zip Code			10g. Ci	tizen of Wh	nat Country	y?	
or death with the Marylan tems 23a or 28a-f show ar must be motified at	alD	1327 Pys	ell Rd.			21541					USA				
er dea'	Funeral	11. Marital Status		12. Was Dec	orces?	er in U.S.	13. V	Vas Decedent of Yes, specify Cul	Hispanic Origin? (S ban, Mexican, Puerl	pecify Yes or N to Rican, etc.)	10-		- Americar White, etc		
# P	ρ	1 ☐ Never Marr	ried 2X Married 4 □ Divorced	1 ∐Yes If Yes, G Year or [ive	1 ∐Yes 2 XX No Specify:					Specify: White			ite	
"natural"	eted	(Spe	15. Decedent's E			16a. Decedent's Usual Occupation (Give kind of work done during most of working						16b. Kind of Business/Industry			
- 4	Completed	Elementary/Seco		College (life. D Co—Ow	O NOT use retire	ed)	9	Во	at Re	ntal	Compa	any
il Hygi other rent, u	Be Co	17. Father's Name	(First, Middle, Last	")					18. Mother's Nar	ne (First, Middle					
2 should be filed within and Mental Hygiene. is marked other than aumatic event, the M	2	John O.	Riley						Alice Ad	ckerman					
d 2 should be filed th and Mental Hyg 7 is marked othe traumatic event,			lame/Relationship		hand				McHenry		ber, City (1541	or Town, S	itate, Zip C	ode)	
tem 2		20a. Method of Dis	seph Guil	LIOL/ Hus	SDanc			sition (Name of atory or other pla		Date		ocation - C	ity or Tow	n, State	
permit. Pages 1 and 2. Department of Health a Important: If item 27 is any injury or other trai			Cremation 3 □ 5 □ Other (Special Control of the Contr		State			ide Cren	. 1	r 4, 20	12	David	evili	le, P	Δ
permit. Departri Importa any inju		21. Signature of Fu	unerel Service Lice				22	Name and Addr	ess of Facility Ne	ewman Fi	unera	al Ho	mes,		
6 2 E C 2		03- Part 5-10-1	Tyur O	Runs		a death D			275, Gran) 21	536	Approximate	
Dhusisian		shock, or hea	ar ∖-f áilure. List only	one cause on	each line.				ring, such as cardia			7.0	!	nterval Betv Inset and F	ween Death
Physician /Medical		disease or condition resulting in death)	on			consequence		1 RCO	LONARY	UMECU	بهم	עועו	24 1	year	
Examiner	_	Sequentially list co	onditions,	b											
uted.	Examiner	Sequentially list co if any, leading to in cause. Enter Under Cause (Disease or	nmediate erlying r injury	Due to	(or as a c	consequence	e ot):								
e executed an and urial-transit	Exa	that initiated events resulting in death)	S	C. Due to	(or as a c	consequence	e of):								
eath certificate be attending physici for use as the bu	dical		•	d											
certific	/Me	IF FEMALE: 23b. Was deceden	at prognant	23c. If yes, ou	itcome of	pregnancy						23d Date	of delivery	<i>y</i>	
death	siciar	in the past 12	2 months?		nant at ti	Fetal dea me of death		Ectopic pregnar Other (specify)				Mon			/e ar
d by the	Physician/Medica	9 ☐ Unknown Part II. Other signi				not regulting	in the un	dorluina couco a	ivon in Port I	23e Did	tobacco	use contrib	nute to the	cause of de	leath?
Attending Physician: The law requires that the death certificate be closth. ector: After this certificate has been signed by the attending physicic by the funeral director, page 2 should be detached for use as the bur	2	rattii. Other sigin	meant conditions	contributing to d	leau i Dut i	lot resulting	illi üle üli	derlying cause g	veri ii r ait i.				B □ Probab		Inknown
law requas been 2 shou	plete									24a. Wa		24b. W	ere autops	sy findings a	available
The I	Completed									per 1 🗆 Yes	opsy formed? 2 No	de	eath? Yes 2	pletion of ca ! □No	ause or
sician certifi rector,	Be	25. Was case referexaminer? 1 ✓ Yes 2 □		Hospital:				Ot	26. Place of Dea						
g Phy er this	Ë	27. Manner of Deat	th	28a. Date	inpatient of Injury oth, Day, Y	28b	. Time of Injury	28c. Inji	4 ∐ Nursing F ury at	fome 5 Res					
endin eath. or: Aff	atio	1 Natural 2 ☐ Accident	5 ☐ Pending investigatio	n '	IIII, Day, 1	ear)	плиу		ork? ⊒Yes 2⊒No						
	Certification: To	3 ☐ Suicide 4 ☐ Homicide	6 Could not be determined	28e. Place	e of Injury ling, etc.	- At home, (Specify)	farm, stre	et, factory, office		28f. Location City or To	(Street a own, State	nd Numbe e)	r or Rural F	Route Num	ber,
To the Hospital or within 24 hours afte To the Funeral Dir completely filled in		29a. Certifier							time, date and place						
the Ho nin 24 the Fu	Medical	(Check only one)	/	miner: On the I and mar	basis of e	xamination a d.	and/or inv		opinion, death occi	urred at the time)
with Volume	2	29b. Signature and	title of certifier		0	a		11-	ise number		7	1	(Month, Da		
	2	30. Name and add	L Duc	completed cau	se of dea	th (Item 23s) (Type. F	Print)	6154		5	101	120	12	
	ر	Paul D	autie IM	ulter	OC	600	1 1	oltv	Aense	· Dri	ne	Ja	Kla	nd	CM CM
Stat		31. Date filed (Mon	nth, Day, Year)	12 %	Registrar's	Signature	bar	Ked	GIS4 Aense					2	1872
Registra	A1	171	MI/ F EO	just		1									

			Please	Type or Pr	int in I	Black Ir	ndelible Inl	k. Ens	ure A	II Copie	s Ar	e Legil	ble.	
		For State		State of M	1arylan		artment of F		and M	lental Hy	/gien	е		
		Registrar	ne (First, Middle, Las	t)		Cer	tificate of L	Death		0.5 : 15	Reg. N	0.20	12	0899
Physicia Medic				untrum J	lr.						Pate of Death Nonth Day Year rch 6, 2012			3. Time of Death 12:26PMM
Examin			f not institution, give		,,,,	-	4b. City, Town, or	riar Cii		c. County of	Death	12.ZUFM		
Funeral		1808 5. Social Security N	Anne Mar			st birthday)	Waldorf	If Under	24 Urs 1	0.0.1.60	Charles			
Director		177-36-4		^ X M 2 □ F	67	Yrs.	Months Days	Hours	Min.		Birth 9. Birthplace (State or Foreign Country)			(Y)
nd now at	2	Usual Residence				, Town or Lo	cation			Nov. 6	, 19	944	PA.	
farylar 3a-fsh iified	ecto	MD.	Charles		1	aldorf	Jation						10	d. Inside City Limits 1 X Yes 2 No
a or 2	al Dir	10e. Street and Nur	mber				10f. Zip Code				10g. C	itizen of Wh	at Counti	
should be filed within 72 hours after death with the Maryland and Mental Hygiene. is marked other than "natural", or items 23a or 28a-f shoraumatic event, the Medical Examiner must be notified at	Funeral Director		nne Marie				20601					ted St	ates	
er dea or iter niner	by Fu	11. Marital Status1 ☐ Never Marr	nied 2 🗆 Married	12. Was Decedent Armed Forces? 1 Yes 2			Vas Decedent of Hi Yes, specify Cuba	ispanic Orig an, Mexica <i>n</i>	gin? (Spec , Puerto F	cify Yes or No Rican, etc.)	-	14. Race - Black,	America White, et	
ırs aftı ural", il Exar		3X Widowed		If Yes, Give Year or Dates.	140	1	☐ Yes 2 No	Specify:				Specify:	Whi	te
72 hou n "nat	Completed	(Spe	15. Decedent's Ed ecify only highest gra			(Give k	ent's Usual Occup	ation during most	of workir	ıg	16b.	Kind of Busi	ness/Indu	ustry
vithin giene. er thar the N		Elementary/Seco	ondary (0-12)	College (1-4 or	5+)		NOT use retired)				\ _C_	mmuni	cati	one
filed val Hyg d othe) Be	17, Father's Name (First, Middle, Last)			TECH	ITCTAIL	18. Mothe	er's Name	(First, Middle			Lati	UIIS
uld be I Ment narke	안		rd Gunth							Lee Ro			_	
24 mm 1			ame/Relationship (Ty Aguilar		-)		g Address (Street a							
1 and of Heal item other		20a. Method of Disp	position		20b. P	ace of Dispos	sition (Name of			ate	_	ocation - C		
Page ment o ant: If ury or		1 ☐ Burial 2 de de la Burial 2 de la Do <i>n</i> ation	Cremation 3 5 Other (Specify	Removal from State)	Hur	-	atory or other plac ematory	· .	3/8/	2012		ldorf		
permit. Departr Importa any inju		21. Signature of Fur	peral Service Licens	e		22.	Name and Addres	s of Facility	y Hun	tt Fun	eral	Home		
40 = 10 O	\dashv	23a Part 1 Enter t	the disease, or comp	new /	MD[[035 01d W					dorf,		
Physician/		snock, or near Immediate Cause (rt tallure. List o <i>n</i> ly or Final	e cause on each lin	e.		: Cardio							Approximate Interval Between Onset and Death
Medical		disease or conditio resulting in death)	on C	a. Due to (or as			Cararo	vascu	ITAI	DISCO	36		-	
Examiner	ř	Sequentially list co	nditions,	b. —										
ted nsit	Examiner	if any, leading to im cause. Enter Under Cause (Disease or	rlying	Due to (or as	a consequ	ence of):								
		that initiated events resulting in death) L	S	c. Due to (or as	a conseque	ence of):							+	
tte be hysicia the bur	Physician/Medical			d										
ertifica ding p	₩	IF FEMALE;		23c. If yes, outcome	of prognar						Т			
eath ce attene	ician	23b. Was decedent in the past 12 r 1 \(\subseteq \text{ Yes} \) 2 \(\subseteq \)	months?	1 Live Birth 4 Pregnant a	2 Fetal	death 3	Ectopic pregnance Other (specify)	У				23d. Date of Month		y Day Year
the duby the	hys	9 🗌 U <i>nkn</i> own		9 🗆 Unknown										
es that igned be de	<u> </u>	Part II. Other signifi	icant conditions co	ntributi <i>n</i> g to death b	out not resu	llting in the ur	nderlyi <i>n</i> g cause giv	en in Part I.						cause of death?
require	Completed									1 🗆	Yes 2			ıbly 4 X Unk <i>n</i> own
sician: The law i certificate has t lirector, page 2 s	ᇍ									24a. Was auto		pric		y findings available pletion of cause of
an: Th tificat tor, pa	Be C	25. Was case referre	ed to medical				26. Pla	ace of Death	h (Check	1 🗌 Yes			Yes 2	□ No
hysici his cer al direc	잍		X ₁₀	lospital: 1 🗌 Inpati	ient 2 🗆 E	R/Outpatient	Othe	r:		ne 5 XResi	dence (6 Other (Specify)	
ding P h. After t funera	ate:	 Manner of Death Matural 	5 Pending	28a. Date of inju (Month, Day		28b. Time of injury	28c. Injury work	?		3d. Describe I	how injur	y occurred		
Attendration death	Certificate:	2 Accident 3 Suicide 4 Homicide	Investigation 6 Could not be determined	28e. Place of Inju	ury - At hor	ne. farm. stre		Yes 2 🗌 I		8f Location /	Street on	d Number o	r Dumi D	oute Number.
tal or rs afte al Dire		4 🗆 Homicide	determined	building, etc			,			City or Tov			nurain	oute Nambel,
To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physici completely filled in by the funeral director, page 2 should be detached for use as the bi	Medical	(Uneck 2	X Certifying Physi	er: On the basis of e	xamination	and/or investig	pation, in my opinio	n, death occ	curred at t	he time date	and place	and due to	the course	a(s) and manner stated
o the orthor orthor orthor	ž	only one) 3 29b. Signature and t	Certifying Nurse	Practitioner: To th	e best of m	y knowledge,	death occurred at the	ne time, date	e and plac	e, and due to	the cause	e(s) and man	ner as sta	ited.
->-0		•	1119		- Elec-	- 6	D185					ite signed (N		
20/2		30. Name and addre	ess of person who co		1 F	23a) (Type, Pr				1.1-1				
δν		Philip W 31. Date filed (Month	190ts KI		ould	Line	Center	V+2	FQ	Walde	ort	MD	200	07
State Registra	-		AR 0 9 201	2 32 Registra	ar's Signatu		Kel							
MII 17 Day 06 0	111			- January	P	· Man								

State

within 2 To the I

only one 29b. Signature and title of certific

31. Date filed (Month

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

MANOJ MATHUR, M.D.,

Registrar DHMH 17 Rev 7/2009 110 HOSPITAL ROAD,

6

PRINCE FREDERICK.

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Day Vear Michael, W. Henley 5:39 PM 03 Medical 2012 4a. Facility Name (if not institution, give street and number) Examiner 4c. County of Death University of Maryland Medical Center. 22 south greenest Bultimore 5. Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Min. (Month, Dav. Year) Country) Hours 216-60-6997 61 Director 1 🛛 M 2 🗆 F Sept. 19,1950 Arkansas or 28a-f show notified at 10c. City. Town or Location Director MD Baltimore 1 🏋 Yes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ō "natural", or items 23a or dical Examiner must be Funeral 1217 W. Fayette Street 21223 USA death \ 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian. Armed Forces?

1 Yes 2 X No If Yes, specify Cuban, Mexican, Puerto Rican, etc. Black, White, etc. ò 1 X Never Married 2 ☐ Married Saltimore, Maryland 21215-0036 hours after 1 ☐ Yes 2X No Specify: If Yes, Give Year or Dates White 3 Widowed 4 Divorced Completed the Medical 15. Decedent's Education (Specify only highest grade completed) Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working filed within 72 al Hygiene. d other than "1 life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Acquisitions U.S. Army 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Ith and Mental F 27 is marked or traumatic ever Department of Health and Menta Important: If item 27 is marked any injury or other traumatic enone. ပ Jess Willard Henley Agnes Mary Sugrue 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mary Henley/ Sister 5039 Gina Lane Federalsburg, MD 21632 20a. Method of Disposition 20h Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) March 06, 1 Burial 2 Cremation 3 Removal from State Baltimore, MD 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory, INC. 2012 Signature of Duneral Service Licenses 22. Name and Address of Facility CREMATION DIRECT 495 Ritchie Hwy. Severna Park, MD 21146 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Teritoritis disease or condition resulting in death) weeks Medical Due to (or as a consequence of) Examiner SCP515 Sequentially list conditions Examine Due to (or as a consequence of) if any, leading to immediate cause. Enter Underlying Cause ibisease or injun and the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): physician Physician/Medical that the death certificate be Division of Vital Records, P.O. Box 68760 as IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 Yes 2 No Day Year Pregnant at time of death Unknown 9 Unknown þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page performe 2X No Yes 2 No 1 Yes Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: Other: 2 No မ 1 Npatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death Certificate: 28a. Date of injury 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred (Month, Day, Year) 5 Pending X Natural s after death.

I Director: Af
ed in by the fu 1 Yes 2 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide determined To the Hospital within 24 hours a To the Funeral C completely filled Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. M.D. . New 001 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 22 South Greene Street Bultimore MD Andrew Walker 31. Date filed (Month, Day, Year MAR 07 37. Registrar's Signature State 2012 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 2 Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** 7:50 P M 03 2012 03 Arlie Eugene Hauser /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Garrett Oakland Nursing & Rehab Center 0akland If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) Social Security Number 6. Sex Days **Funeral** Months 1**⊠** M 2□ F 30 ΜĎ 05 1933 212-32-7925 78 Director Usual Residence of Decedent 10d. Inside City Limits filed within 72 hours after death with the Maryland 10c, City, Town or Location 10h County 10a, State d other than "natural", or items 23a or 28a-f show event, the Medical Examinat must be notified at 1 ☐Yes 2 No Director 0akland MD Garrett 10g. Citizen of What Country? 10f Zin Code 10e. Street and Number 1506 Gnegy Church Road 21550 USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married 1 ☐Yes 2KNo Specify: Completed by White 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) self-employed carpenter marked other 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If item 27 is marked oth any Injury or other traumatic event Be Vernie Pricilla Gnegy John David Hauser 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 1506 Gnegy Church Road, Oakland, MD 21550 Judith L. Hauser-wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Surial 2 ☐ Cremation 3 ☐ Removal from State St. John's Cemetery 3/7/2012 Oakland, Maryland 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility David A. Burdock Funeral Home PA 21. Signature of Funeral Service License 21 N 2nd St., Oakland, MD 21550 Part / Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition Physician resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of Examine and Due to (or as a consequence of) physician ar Physician/Medical as t attending IF FEMALE: use yes, outcome of pregnancy 23d. Date of delivery 23h. Was decedent pregnant 3 Ectopic pregnancy Live birth 2 Fetal death Year Month for in the past 12 months? 4 ☐ Pregnant at time of death 5 Other (specify) the detached 1 ☐ Yes 2 ☐ No 9 Unknown signed by se contribute to the cause of death? Pa ò e e 3 Probably 4 ☐ Unknown ∃No Completed peen 24b. Were autopsy findings available prior to completion of cause of has death? 2 🗆 No 1 ☐ Yes Attending Physician: or death. 2 Be G ☐ Other (Specify) Certification: To 2 d Number or Rural Route Number,

the death certificate be executed Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifit completely filled in by the funeral director,

Baltimore, Maryland 21215-0036

9 LI Unknown						
art II. Other significant	conditions co	ontributing to death but not	resulting in the und	lerlying caus	e given in Part I.	23e. Did tobacco us 1 ☐ Yes 2 [
						24a. Was an autopsy performed?
5. Was case referred to	medical				26. Place of Dea	th (Check only one)
examiner? 1 ☐ Yes 2 ☐ No		Hospital: 1 ☐ Inpatient	2 ER/Outpatient	3 □ D0A	Other: 4 Nursing H	lome 5 ☐ Residence 6
7. Mann Death Natural 5 □ 2 □ Accident	Pending investigation	28a. Date of Injury (Month, Day, Yea	28b. Time of Injury	28c.	. Injury at Work? 1 □Yes 2 □ No	28d. Describe how injury
3 ☐ Sulcide 6 ☐ 4 ☐ Homicide	Could not be determined	28e. Place of Injury - building, etc. (Sp	28f. Location (Street and City or Town, State)			

29a. Certifie 29b. Signature and title of certific

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Thomas G. Johnson, M.D., 311 North Fourth St, Suite II, Oakland, MD 21550

State Registrar 31. Date filed (Month, Day, Year) -62012



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ March 2, William Hubert Hinebaugh JR 2012 10:45 A M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City. Town, or Location of Death County of Death Moran Manor Nursing Center Westernport Allegany If Under 1 Year If Under 24 Hrs. 7. Age (In yrs, last birthday) **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign 234-24-4992 Days March 23 West Virginia **Director** 1 M 2 F 1924 87 28a-f shov 10a. State ral", or items 23a or 28a-f sho Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Directo WV Mineral Piedmont 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 26750 39 Jones St United States 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. er than "natural", or the Medical Examin Yes 2 No by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 72 hours after 1 Yes 2 No Specify: 3

Widowed 4 □ Divorced Specify: white Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) 1 and 2 should be filed within 72 Health and Mental Hygiene. item 27 is marked other than Elementary/Secondary (0-12) College (1-4 or 5+) Paper Manufacturer Fork Lift Operator unknown or other traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) William Hinebaugh SR Agnes Pearl Mason 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4042 Treely Road, Chester, Virginia 23831 Flora Johnson/daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Page 1 and Department of Hamportant: If ite any injury or ot Date 1 X Burial 2 Cremation 3 Removal from State Potomac Mem. Gardens 03/05/2012 Keyser, West Virginia 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Sepvice Licenses 22. Name and Address of Facility Boal Funeral Home 111 Church St, Westernport, Maryland 21562 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ cut were disease or condition Medical resulting in death) Due to (or as a consequence of Examiner Sequentially list conditions Due to (or as a consequence of): if any, leading to immediate Exami sician and burial-transit requires that the death certificate be executed Cause (Disease or injury that initiated events Due to (or as a consequence of): resulting in death) Last physician the buria Physician/Medical Division of Vital Records, P.O. Box 68760 attending pl IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Month Year Pregnant at time of death Day 9 Unknown Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Hnknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an or Attending Physician; The law this certificate has page performed? Yes 2 No Be 25. Was case referred to medical 26. Flace of Death (Check only one) examiner? 2 No Hospital Other: 1 🗌 Yes မြ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Hursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending nours after death.

neral Director: Aft

filled in by the fur 1 ☐ Yes 2 ☐ No Accident Investigation 6 Could not be 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 24 hours a Funeral L Hospital Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the I within 2

To the F

complet Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D21244 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dr. Jesus Tan, 4 Broadway, Frostburg, Maryland 21532 31. Date filed (Month, Day, Year) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 26 Day 201 2ar Feeth. 8:46P Loretta Mae Harding Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Oakland Garrett Garrett County Memorial Hosp. Social Security Number 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🗆 M 2 💢 F Hours July 12, 1934 Maryland Director 217-30-1671 77 Usual Residence of Decedent 23a or 28a-f show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked outher than "natural", or items 23a or 28a-f sho amportant: If item 27 is marked outher than "natural", or items Lambalto and item in hirty or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 No Friendsville MD Garrett 10e. Street and Number 10g. Citizen of What Country? Funeral 21531 U.S.A. 34 Park Street 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces? 1 ☐ Yes 2 🔀 No Black, White, etc. 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2 X No Specify: If Yes. Give Specify: 3 X Widowed 4 ☐ Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Garrett County Elementary/Seconday (0-12) College (1-4 or 5+) School Bus Driver Board of Education 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Coddington Sines Cleda Glenn 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Fixe Pot Sville, Kenneth Harding, Jr. / Son 4856 Accident Friendsville RD, MD 21531 20a. Method of Disposition 1 Disposition 3 Removal from State 20c. Location - City or Town, State 20b. Place of Disposition (Name of Hack Disposition) 2/29/12 4 ☐ Donation 5 ☐ Other (Specify) Cemetery Friendsville, MD 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Newman Funeral Homes P.A. Miller St., Grantsville, MD 21536 179 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardi, c or respiratory arrest, shock, or heart failure. List only one cause on each line. t and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a cor Examiner Sequentially list conditions, Examine cause. Enter Underlying Cause (Disease or iinjury that the death certificate be executed g physician and as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 3 Ectopic pregnancy Pregnant at time of death 5 Other (specify) Day 1 Yes 2 g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 Hospital or Attending Physician: The law requires t 24 hours after death. La hours after death. Luneral Director: After this certificate has been sign eted filled in by the funeral director, page 2 should be eted filled in by the funeral director, page 2 should be 1 Yes 2 No 3 Probably 4 Inknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an autopsy perform Division of Vital Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 \square Nursing Home 5 \square Residence 6 \square Other (Specify) 2 No Hospital opatient 2 ER/Outpatient 3 DOA မ 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined within 24 hours af To the Funeral Di completed filled in

State Registrar

Medical

29a. Certifier (Check only one 29b. Signature and

Robert A.

31. Date filed (Month, Day, Year)

MAR -

DHMH 17 Rev 7/2009

2,27.12

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Goralski

2012

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On Me basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29d. Date signed (Month, Day, Year)

2/27/2012

29c. License number

D23979

N. Fourth St., Oakland, MD 21550